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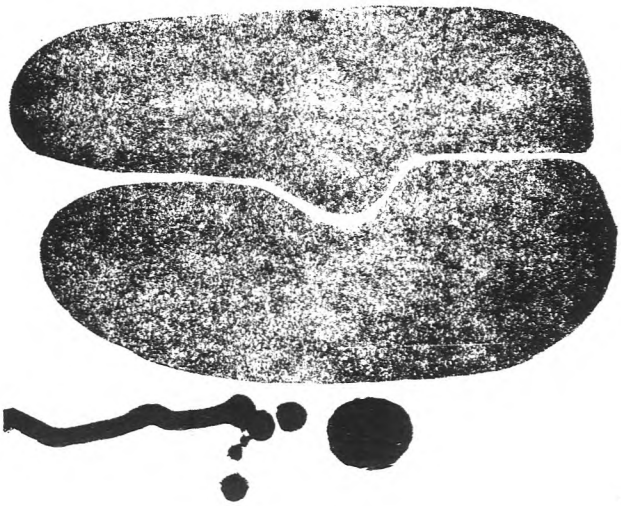

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Dr Heather Suckling, president of the Balint Society.

The Balint Society:

The Balint Society was founded in 1969 to continue the work begun by Michael and Enid Balint in the 1950s. The aim of the Society is to help general practitioners towards a better understanding of the emotional content of the doctor-patient relationship. The Balint method consists of case discussion in small groups under the guidance of a qualified group leader. The work of the group involves both training and research.

Membership of the Society is open to all general practitioners who have completed one year in a Balint-group. Associate membership is available to all those involved in health care work including doctors, nurses, psychotherapists and counsellors. Students are especially welcome.

The Society holds a series of lectures and discussions each year at the Royal College of General Practitioners in London. There is also an annual residential weekend at Oxford and a study day for practice nurses.

The Society is always ready to help with the formation of new Balint-groups. The Group Leaders' Workshop provides a forum for all Balint-group leaders including GP Course Organisers to discuss their work.

The Society is affiliated to the International Balint Federation, which co-ordinates Balint activities in many countries and organises an International Balint Congress every two to three years.

The Journal appears annually and is circulated to all members. There is an annual Essay competition with a prize of £500.

Editorial

Training, Yes, But what about Research?

Michael Balint used the phrase 'research-cum-training' (*cum* being Latin for 'with') to describe what went on in his revolutionary new seminars for general practitioners. Later it was changed to 'training-cum-research' but, either way round, we should not forget the important research component. His original idea was that the group, as well as training its members in psychological medicine, woud be a customised reasearch instrument with which to investigate the psychologically unexplored world of the family doctor's surgery. The project was a search for meaning in a specific kind of human interaction and it deserves to be recognised as one of the earliest (and best) examples of qualitative research in primary care. *The doctor, his patient and the illness* was followed by a number of monographs on different themes (asthma, night calls, repeat prescriptions) and a series of books (at lengthening intervals) on the group process and its more general application to understanding general practice. Michael and his colleagues also tried to do some quantitative research on the doctors who took part in the groups. Here the idea was to evaluate the benefits of the 'training' part of the group package. In the book *A study of doctors,* they describe how they assessed the progress of all the doctors who took part in the early groups and graded them according to the improvement in their sensitivity and their psychotherapeutic skills. Or, in other words, the extent to which they had succeeded in achieving the 'limited though considerable change in personality'.

This kind of research looks at the outcome of training for the doctors rather than the process in which doctors and patients are engaged. Is Balint training effective? Those of us in the Balint movement are in no doubt about the benefits for both patients and doctors. We know from personal experience how it has changed our professional llives for the better. But sceptical outsiders not unreasonably will ask us for evidence. It is to persuade them, as well as to satisfy our own curiosity that we need to continue thinking about and doing research.

Convincing the sceptics will not be easy. Researchers trying to evaluate the effectiveness of Balint training are faced with formidable difficulties. The first problem is to decide whom and what to evaluate. Our patients are the ultimate beneficiaries of any improvement in our skills: can Balint training can be shown to make an difference to them? Does having a Balint doctor make an impact on health outcomes? And what sort of end points should we choose to look at? Do these fortunate patients get rid of their symptoms more quickly? Is there an improvement in the quality of their lives as a result of having a doctor who is more willing to listen? Is it possible to compare these patients' experiences with those of a control group who have been deprived of Balint-style primary care?

An alternative, and more popular method is to examine the doctors themselves to see if that 'limited though significant change in personality' can be detected. Doctors emerging from Balint training can be submitted to psychological profiling to see if they have acquired a greater capacity for empathy or intuitiveness. Or even a greater interest in their patients as human beings. And if we are to measure change, they need to be tested both before and after their Balint training. Even if this is possible we are left wondering whether any change for the better is due to the group experience or to other factors which have contributed to increased clinical skills and personal growth. Again a control group is needed in order to satisfy the criteria of evidence based research. We should bear in mind that Balint and his colleagues concluded in *A study of doctors* that only about 40% of North London GPs were capable of benefiting from Balint training in any case. If this is still true, considerable numbers would be needed to demonstrate any significant quantitative effect.

Perhaps it would be more useful and less frustrating to consider the methods of qualitative research. This approach is much more helpful in finding answers to questions about why and how things change in people's lives. Qualitative researchers interview their subjects without scales and checklists. They listen to what people have to say in a semi-structured conversation. They are interested in everything, and the answers they record may be the basis of new and important questions. Qualitative research on Balint doctors and the patients might be a more fruitful line of enquiry for us to pursue. Using these methods (which now have academic respectability) we can hope to define more accurately and specifically the ways in which the group experience can change the way patients and doctors think – and feel – about each other and about their lives.

In this issue of the Journal of the Balint Society we are publishing two papers which illustrate the qualitative approach to Balint research.

In a paper from the United States, Dr Michael Floyd and colleagues have studied a Balint group for rural family doctors and nurse practitioners in the state of Tennessee. They used qualitative methods to assess the impact of the group experience over an 18 month period on the physicians and nurses who made up the group. Their evidence shows that participation in the group helped them to express and share emotions about their patients and also to break down the interprofessional barriers between nurses and physicians.

Susan Hopkins in her paper ('Six doctors and a lunch party') uses semi-structured interviewing with qualititative analysis to examine the attitudes of Balint doctors to counsellors working in their practices. Her results show that many of

us have rather uneasy feelings about our professional relationship with counsellors, in spite of our supposed psychological expertise.

Finally, we would like to celebrate the arrival of a newly published book which describes the work of the latest Balint research group in Britain. The group met regularly for five years (1994-1999) to examine the defences which doctors make use of in order to protect themselves from too much exposure to patients' emotions (and their own). The book is called *What are you feeling, doctor?* and it is reviewed by Pat Tate on page 39.

Balint research seems to be flourishing and a new spirit of inquiry and investigation is invigorating the work of Balint doctors. Research has been described as 'organised curiosity' and curiosity is the driving force that keeps us interested in our patients (and ourselves). We still have much to learn about the doctor-patient relationship. We also need to find ways to show our medical education colleagues that Balint training can help the next generation of family doctors as much as it has helped us. *Training-cum-research.*

JOHN SALINSKY

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The Balint Society Website

The Balint Society now has its own internet website.

The address is **www.balint.co.uk**

Unlike some addresses, this one is very easy remember and to find.

When you have located it on your computer (if in doubt ask any eight year old child) you will find a whole sheaf of pages providing all sorts of interesting and useful information.

Pages include:

- NEWS of recent events and forthcoming meetings and conferences.
- FAQ (Frequently Asked Questions) about Balint: helpful for newcomers.
- GROUPS: How to start new groups and get help with leader traing.
- INTERNATIONAL PAGE: Information about the International Federation and news about the next International Congress.
- JOURNAL. This page shows the contents of the current issue and the editorial in full.
- BOOKS. A bibliography of the best Balint books in English. Plus a handful of recommended papers.
- LINKS. By clicking on **www.balint.co.uk** you can easily go to the American, German and Finnish Balint Society websites. More are coming all the time.
- THE BULLETIN BOARD enables you to ask questions about the Balint Society and have discussions with other people who have contacted the site.

Have a look at the Balint Society Website NOW! Tell everyone about it! Refer anyone who is remotely curious about Balint to **www.balint.co.uk.**

Balint Training and Psychosexual Nursing Care

Talk given to The Balint Society

26 October 1999

Doreen Clifford RGN SCM MTD Cassel Hospital Certificate

And now this is 'an inheritance'
Upright, rudimentary, unshiftably planked
In the long ago, yet willable forward

Again and again and again.
('Beowulf' A new translation by Seamus Heaney)

In this talk the quotation illuminates both the influence of Balint and Main on seminar training with nurses in psychosexual care and the fresh initiatives being developed by the Association of Psychosexual Nursing. This is discussed as follows:

A The inheritance of seminar training left to us by Michael Balint and Tom Main
B What stops the work?
C The establishment of the Association of Psychosexual Nursing
D An appreciation of four essential nursing elements contained in Balint training

A THE INHERITANCE OF SEMINAR TRAINING

In exploring this inheritance, four of the 'unshiftable planks' left to us by Balint and Main that are essential to seminar training are illustrated and considered: 1. The study of the practioner patient relationship, 2. The recognition of the body/mind continuum, 3. The spoken and unspoken agenda of the patient. 4. How feelings in a group can mirror those in the practitioner-patient relationship.

1. The study of the practitioner patient relationship

Michael Courtenay (1993) spoke of 'Tom Main's calm, unwearying insistence on observation of the doctor-patient relationship during the consultation and how it came to have an almost hypnotic effect upon his own practice.'

Here is an example of someone who lost her ability to observe the nurse-patient relationship in situ but regained it in a seminar with colleagues:

An experienced nurse reported on meeting a new patient, an older woman, who had advanced on her angrily shouting that she had been made to wait. Indeed, the consultation had been double booked. The nurse had been unaware of this and apologised but the woman was unforgiving. This nurse, normally somewhat soft hearted, surprisingly turned on the patient and showed her anger at being attacked in this way.

They finally settled and the patient, sent by her GP, told a story of loss of libido with a previously loved partner, speaking of him contemptuously as 'that little runt'. In other relationships she had maintained her own home but she had sold up to move in with this partner some months earlier and they had been happy. Her mother died this year. Now she had lost her libido. Her GP had treated her with HRT to no avail, so she had insisted that he send her for counselling help. The nurse raised the issue of the angry outburst. The patient said she had been surprised at the nurse's response, she lost her temper a lot and usually this frightened people away. In fact she had been warned about her behaviour at work and feared that she could lose her professional well paid job.

After reporting this, the nurse told the seminar group that she could not work with this battling angry woman and would refer her on. The other seminar members mostly took the nurse's part, until someone asked what the nurse's anger was about. When the group began to look at the nurse-patient relationship, filled with angry feelings and the hidden threat of rejection by the nurse, they were puzzled. The nurse said how frightened she had been by the patient's outburst and that she felt no compassion for the patient and could not work with her. It was pointed out that the nurse had lost her accustomed professional identity, she was usually a thoughtful person who struggled to understand feelings and recognise a patient's pain. Was this an indication that the patient had lost her usual self also?

When all the patient's losses were considered by the group; loss of her mother, her previous home, her love and respect for her partner, her fear of losing her job and loss of her valued sexual feelings, there was recognition that her anger was possibly a part of her loss and grief.

At the following seminar, the nurse told of her continuing work with the patient. The woman had wept uncontrollably at the recognition of her losses. Yes, she missed her independence, her loved mother who had understood her, she was afraid that her partner would not continue to love her after this apparent rejection of him by her loss of libido, and she was really frightened of losing her job. "Am I going mad?" she asked. Her anger frightened her, just as it had the nurse, whilst bereavement can sometimes leave people afraid for their sanity. (Parkes & Markus 1998)

2. Recognition of the body/mind continuum

No doubt all have examples of how a patient's posture has contributed to making a diagnosis. So too in seminars, sometimes the posture of a colleague can indicate the unresolved distress carried by them from the patient brought for discussion.

On one recent occasion in a seminar, the voice of a specialist nurse counsellor reporting an encounter with a patient, became quieter and difficult to hear. It was pointed out that she had almost curled up when reporting on her work with this patient who had been seeking counselling for infertility. The nurse, surprised, recognised the similarity to the posture to that adopted by the patient she was describing. She went on to speak, in normal tones, about her difficulty at containing and working with so much pain from the patient and her own feelings of useless in the face of this suffering.

What might have been the outcome if her quiet voice and posture had been ignored or unvalued as a contribution to the discussion?

3. The spoken and unspoken agenda of the patient

A practice nurse reported to a seminar: *A woman attended for a cervical smear test. It was an everyday event for the experienced nurse, who was proud of her skills to undertake this task competently and with as little discomfort as possible. All went well. She asked the woman, as she often did on such occasions, if all was well with love-making for her. "It is a long time since we made love" she said, "My husband has cancer and had major surgery to his face and jaw, he is so disfigured that I can hardly recognise him." The nurse indicated her concern for them both. "He has been so ill," she continued, describing her care of him, "He said the other day, I can't even kiss you properly."*

The nurse now found herself in a difficulty. She had been consumed by deep sympathy for the woman. Now, to her discomfort, the idea of the kiss from this desperate disfigured man caught her unawares and she felt distaste and was extremely uncomfortable. Feeling guilty about her response, she finished the consultation.

It is interesting to reflect upon the feelings experience by the nurse. First to consider the powerful sense of compassion she felt. She used this to remain close to the woman who spoke of the pain and distress of her husband's illness and her own tiredness and stress at caring for him. The nurse was able to remain alongside her and show by her professional demeanour that she understood her distress and its appropriateness to the occasion. However, the nurse also experienced feelings of disgust and felt guilty about that. She found those unwanted feelings too difficult to deal with and brought the consultation to a close. It is interesting to consider that the difference was, that some feelings were more welcome than others. That is compassion, understanding and patience not only felt comfortable, but were shown and shared in the clinical encounter. Whereas, disgust and guilt proved too difficult. No longer could they be seen as shared feelings but the nurse took them to herself, judged them there, and wanted to get rid of them. The result was the end of the work with the patient on this occasion.

4. How feelings in a group often mirror those in the practitioner patient relationship.

A practice nurse told of meeting a pretty plump 21 year old woman who had brought her baby and toddler for vaccination. She recognised her as someone she had invited more than once for a repeat cervical smear. The two tinies safely lodged with a young friend outside, the nurse started to get ready for the cervical smear procedure. She enquired about contraception. "Oh we don't do it now, so there is no need for any." So when did you last have intercourse? "Oh, um, last night. It wasn't with my partner, but with the children's god-father, he's a good friend. It was quite a surprise really. No we didn't use anything."

The leader, puzzled by her own strong feelings, unusually, interrupted the story at this moment to enquire what feelings seminar members had about the patient. Hesitantly and with some difficulty, members 'confessed' to feeling critical and irritated by the patient. They did not like to admit to these feelings about a patient; professionals after all are supposed to remain objective about patients' behaviour! What was the basis for these feelings? They came from the nurse's account. What were her feelings about the patient? This honest nurse admitted to feeling critical also but blamed being middle aged and middle class for this.

Other members thought so too. BUT, why did it happen with this particular patient? It was not usually evident in this nurse's work. Could these feelings have derived from the patient's view of herself?

The apparently uneventful smear completed, the nurse said to the patient something like, "Well you have a busy life", meaning two little ones to care for. The patient seemed offended, took this as a criticism and left hurriedly.

The nurse, in thinking this through in the group, felt that the patient's response could be evidence for the critical feelings having emerged from the patient's view of herself. She was disappointed at not giving the woman opportunity to talk over the events of the unprotected sexual intercourse and consider contraception. In other words, she recognised that the work had been incomplete.

We may note that it was when the leader became aware of particular feelings in herself that she tested them with group members, and similar feelings were brought into the open. When these unwelcome and unwished for feelings were recognised, explored and discussed, members were freed from them, work could continue and understandings attempted. For her part the presenting nurse was then free to explore the events of the consultation again and, without shame, recognise that her critical feelings had stopped her work with the woman. This transference of feelings from practitioner patient relationship to

the group discussion is recognised by others after Balint. Schon (1983) uses the description 'the hall of mirrors'; Buchinger (1983) describes the experience as 'resonance phenomena'. Whatever the words when feelings, freed from moral overtones can be recognised and studied, this can lead to an understanding that *they may emanate from the patient's world.*

B What stops the work?

Experience leads us to believe that some feelings cause distress in particular people, whether they are patient or practitioner. Such pain is to be respected and cared for. In the practitioner by continuing training in skill development and in the patient by the professional clinical team.

With two or three clinical examples given here, unrecognised and unwelcome feelings interrupted work with patients. Repressing unwanted and uncomfortable feelings stopped work continuing.

In basic nurse training there has been a tradition and expectation that only objective and positive feelings should be expressed about patients. (Menzies 1976) In fact, in the work of nurses and doctors, many feelings arise. These can range between feelings that are acceptable and to others unwelcome and unwanted. This 'hierarchy' of feelings seems to arise from a learned professional morality which prevents recognition of some feelings that have come to be seen as unacceptable in relationship to patients.

What are these different categories? We might consider that kindness, benevolence, sympathy, acceptance, firmness, sometimes even irritation, are among the OK feelings. However, when uncertainty, criticism, embarrassment, and disapproval play a part, then things get difficult. When even stronger feelings such as anger, hatred, arousal or disgust arise and are difficult to acknowledged by oneself, then the temptation is to withdraw from the consultation and the work stops. By not allowing or acknowledging difficult feelings or blaming ourselves and our "middle class angst" for them, we fail to acknowledge that feelings have a potential to alert us to the inner world of the patient.

A number of factors have a part to play in this; how the practitioner is feeling on a particular occasion, can move the balance of acceptability. Feeling well and in good spirits or conversely, tiredness or ill health along with the inevitable shortage of time, can all contribute to changing the pivotal place in the balance of recognising feelings.

Continuing seminar training offers support to recognise and explore without shame, subjective feelings that interrupt or prevent work whilst recognition of feelings can give opportunity to work alongside the patient to understand. (Clifford 1997)

Main (1987) wrote, 'But if we dare value subjectivity then we may come to legitimize the study of the subjective feelings of (practitioners), the ways they at present are ignored in unconscious and undisciplined ways and how they can be used in deliberate and disciplined fashion to throw light on the patient and his problems.'

What do you think? What are your experiences of the feelings that stop work?

C The establishment of the Association of Psychosexual Nursing

In 1973 in response to many requests from family planning nurses for training to respond to patients seeking help with sexual problems, the then Department of Health and Social Security set up research to test the feasibility of seminar training for nurses. From this project a year's course 'An introduction to psychosexual counselling for nurses' was developed by the Joint Board of Clinical Nursing Studies (Course 985 and ENB 985). Jane Selby (1985) ran this seminar based course combined with the theory of emotional development across the lifespan, at Lewisham Hospital for 10 years. (Randall 1992)

During these years and since, a number of training seminars for nurses were run by nurses across the country. A London seminar continued for nurses who had completed the course, other nurses seeking help in responding to patients with sexual difficulties, joined seminar training in Winchester, Bath (Snow 1994), Central London and Plymouth. In Ipswich a seminar for nurses was run by Dr Rosemary Lincoln for a number of years. Numerous Study Days and Workshops in psychosexual care have been sought and organised for nurses and many specialities including continence care, family planning, midwifery and ward sisters from medicine and surgery and for midwifery tutors.

An advanced family planning course (A08) introduced psychosexual seminars into the training promoting awareness and understanding. (Bell, Rutter, Selby & Ward 1997) From such varied training work arose a network of psychosexual nurses who met for some fifteen years in London twice yearly, to discuss and compare their work and take part in seminars. From this Network of Psychosexual Nurses, trained and experienced in seminar work, the Association of Psychosexual Nursing was formed in 1998 and became a registered charity in 1999.

How the Association is developing psychosexual nursing awareness and training

The work is slow. There is resistance in nursing to the work of caring for sexuality. Yet Waterhouse and Metcalfe's research (1991) shows that many patients wish nurses would raise sexual issues with them.

Awareness of psychosexual issues is urgently needed for recognition of the disturbances to the sexual self, experienced by many people, for example, following childbirth. Most practitioners will recognise the question, "is everything alright down below?" asked by many post natal women.

Disturbance to sexual functioning is met in men and women following some drug treatments; with illness, cancer, hospital admission,

and following surgery, grief and loss. (Parkes and Markus 1998). The necessity is for practitioners seeking to offer holistic care, including nurses, physiotherapists and radiotherapists, to respond in their everyday work. There are difficulties for some nurses (perhaps some doctors too) in speaking about sexuality. "It is difficult enough to talk about sex with my own lovely children," said one nurse. There is a fear of being seen at best, as a nosy parker. It seems that for some professionals the fear of patients misunderstanding an offer of this kind is just too difficult for them to begin.

So much could be done to recognise potential disturbance by the health care practitioner with ordinary words. Sometimes a simple phrase can be helpful, "do you want to tell me about how this is affecting your life?" or "how do you and your partner manage this difficulty" or "does this affect your sexual life". Most nurses seem to find that talking about their approach in seminars is helpful and conducive to the growth of developing their own unique and skilful approach.

A Macmillan nurse told of a follow up out patient seen by her and a doctor. "Is everything alright, how is sex?" he said. "Eleven years, eleven bloody years I've had treatment here and this is the first time anyone has asked me that! Why didn't anyone ask before?" was the reply.

Some examples of what the Association is offering

- A variety of training and support for nurses with study days and work shops organised on request. A Workshop was held in Liverpool for practitioners in Gynae/oncology in May. A request has been received from Glasgow for something similar, Spring 2000.
- Two Study Days a year are open to all nurses and other health care practitioners. In May, the focus was 'Termination of pregnancy'. On November 20 the focus is "Psychosexual needs of the oncology patient." Seminars are run in the afternoons for people attending.
- Seminars are to be integrated into the Rcn course in fertility nursing, Spring 2000.
- This year the Association provided a speaker at Royal College of Nursing Gynaecology Conferences in Edinburgh and Birmingham to speak on the need for awareness to psychosexual issues in everyday nursing care.
- Members of the Association have produced a book, 'Caring for sexuality in health and illness' to be published by Churchill Livingstone, Spring 2000.
- Regular continuing training seminars are held in central London. There are two advanced seminars and a leaders' seminar in London. There are regular seminars in Cornwall, Bedford, south London and west London and a seminar in Bath begins in the new year.

How the Association is carrying 'the inheritance' forward with training initiatives

'yet willable forward
Again and again and again.'

Somewhat in defiance of the inherited tradition, we have developed an expectation that seminar members take responsibility for their learning in a number of ways.

Written work is set at the end of term for reflections on clinical practice related to seminar working. Members keep a written account of all seminars noting new learning or fresh thinking taking turns to distribute these to the other members. Leaders expect members to keep a reflective diary and some, a nursing journal.

Some seminar groups hold reading discussion seminars each term to support the understanding of the relationship of texts to practice.

The Association have recently gained Accreditation from Greenwich University for a module in psychosexual awareness for health care practitioners, based upon seminar training, to begin Spring 2000.

Dr Jan Savage, nurse and anthropologist, of the Royal College of Nursing Research Dept. has just completed a pilot study with one of the Advanced Seminars into seminars training as an educational tool in nursing. This will continue.

An Advanced Seminar has members researching the use of drawing to help in understanding vaginal fantasies with some inarticulate patients seeking help with failure to achieve sexual intercourse.

D An appreciation of four essential nursing elements contained in Balint training

In the light of the current discussion about nurse education, the Association has come to appreciate the importance of encouraging the use of seminar training to increasing nursing skills generally. Seminar training encompasses many of the elements considered so important in developing nurse training programmes.

1. Continuing training as a support system.
   There is currently little acknowledgement of the feelings experienced in the work of nursing. Without such support there is a likelihood of the development of defensive responses and consequent damage to nursing sensitivity toward patients' feelings.
2. Supervision.
   This is the study of actual clinical work within a peer group of colleagues similarly employed. It encompasses Benner's (1984) description of the 'laying bare of knowledge embedded in nursing'. Evidence from seminar training shows an increase in confidence and caring skills.
3. Reflective practice.
   Within a colleague group, developing skills by examining practice; reflection ON practice leads to reflection IN or during practice and the development of further clinical skills. (Schon 1983)
4. Action research.
   Balint originally described his work as 'research cum training' seminars. Research

is employed in recognising and identifying difficulties, trying out responses, reporting back, continuing with the work. (Penman 1998)

The Association recognises that seminar training has as important part to play in the future of nurse education. In particular, the development of the professional use of self in psychosexual nursing care in responding to the needs of patients.

It will be interesting to see whether cooperation between the Balint Society and the Association can further the aim of seeing the study of the practitioner-patient relationship accepted by educationalists in both disciplines as central to improving clinical practice.

It was a privilege to meet members of the Balint Society and I should like to thank them for their welcome and the interesting discussion that followed the paper. My special thanks to Drs Stephen Pasmore and David Watt for arranging the meeting.

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Looking Back, Looking Forward: A Medicine that is Ours to Practice

by Andrew Elder, General Practitioners, London.

Address given to the Balint Society on 22 February, 2000

Introduction

In his book on Michael Balint's work, published in 1996, Harold Stewart concludes a brief introduction to Balint's contribution to Applied Psychoanalysis with the following words, stated quite simply, but with an arrestingly matter-of-fact tone, at least as they might strike a committed Balint doctor's ears! He writes that 'with Enid Balint's death in 1994, it will be of interest to see if this work continues to be developed in the absence of the Balints'.

This simple statement surely represents a serious challenge for our Society, and its members. We are on our own. It is our responsibility. No-one else's. What are we to make of it? After all, to develop the Balint's work was the founding purpose of our Society, its raison d'etre.

For Balint practitioners clinical work comes to life through an interaction between general practice and psychoanalysis – and exists in what might be thought of as the **'middle ground'** between the two. Balint work gives rise to a professional world in which the personal insights and attitudes of mind that derive from psychoanalysis can come into focus as an integral part of the practice of medicine. These two different but not incompatible sources of human knowledge – psychoanalysis and medicine – become integrated through the experience of the group process for each individual differently. In doing so they make possible a more **3-Dimensional medicine:** one with a depth of interpersonal focus as well as the more conventional cross-sectional medical view. This process occurs for each individual differently and centres on that doctor's individuality, and not on the teaching of any more generalised 'correct way of doing things'. This emphasis on the uniqueness of individual – doctors as well as patients – is one of the key distinguishing features between the Balint approach and other approaches to medical learning.

Returning to Harold Stewart's phrase, it is noticeable that he says '**developed** in the absence of the Balints.' Not simply continued, but developed. The word 'develop' might be thought of as enlargement: increasing the number of members of our Society, the number of groups meeting on a regular basis, or the number of leaders attending our workshop etc. We do often have discussions which ruminate about such things, but they don't often seem to get us very far. The word might also be taken in the sense of intellectual development – can we continue to develop and extend the ideas we have inherited? In many areas, members of our Society have remained actively involved in the development of ideas. There is a clear line of research deepening our understanding of the doctor-patient relationship, which has been continuing recently in the work of the 'Defences group' led by Michael Courtenay. This represents an almost uninterrupted response to Michael Balint's original invitation to study the pharmacology of the drug doctor. However, the direct influence of the Balints is still close-at-hand in this work. There is a related need to study the intricacies and difficulties of group leadership, and how best to learn from each other about these, to develop our skills and train others. John Salinsky raised an interesting question in his paper 'Hanging by a Thread' in which he asks whether our understanding of what happens between Doctors and Patients in consultations has fed into a corresponding development in the techniques of group leadership? Perhaps we will have a chance to develop some ideas about this in the Leader's workshop? It is well known that many members have been active in adapting groups for trainees on Vocational Training Schemes and the Society's annual Oxford week-end is a well-established venture.

It is to a third and slightly different meaning of the word 'develop' that I want to pay most attention – to that associated with growing up; with the difficult tasks and transitions of human development – as an organisation with a purpose, with tasks to perform, which will enable our work to continue to be developed. I want to do so by reflecting on some factors which might impede our development as a Society, and I want to discuss our relationship with other organisations: other Societies, Institutions, or collections of individuals who might be thought of as close relatives in the **middle ground,** and in particular, the growing number of psychotherapists and counsellors who work in primary care.

In order to begin to attend to Harold Stewart's question in more detail, I want to remind us first of last year's Balint Memorial Lecture given by another psychoanalyst colleague and friend of this Society, Jonathan Sklar.

Balint Memorial Lecture 1999

You may remember that he describes two cases reported in his current GP group – one to do with a doctor's continuing idealisation of a past teacher; the other a case concerning a series of connections between a family dealing with a dying father and the private meaning of these events for the GP – and he goes on to ponder his choice of cases, and describes himself realising that his choice has something to do with the need to give up a childlike relationship with a dead parent in order to understand it and move on in life. He says 'I am thinking of this in relation to the Balint Society having a relationship of homage to Michael and Enid Balint, which needs to be

beyond a relationship to wonderful, but now dead parents. Knowledge and technique needs to be understood by the present generation beyond the dead parents, in order for the work and the Society to stay alive and to move forward, rather than remaining with an unmourned past. The work that the Balints achieved in relation to ... General Practice in this country and far beyond, has been immeasurable. I have no doubt that, to both of them, the idea of continuing beyond their work would be essential, as the only means of having a sense of being alive rather than being in a state of unconscious repetition ... This is a painful task for each of us, as well as for the learned Society, that must of necessity, look forward within the context of knowing its great history.'

I speak for myself when I say that the loss of Enid Balint was a great one; and that as well as it being a personal loss, that of a good friend and colleague, almost more so, it was the loss of someone who knew our GP world so well and at such a depth, and like a good mother, was patient in **our slowly emerging** understanding of it. But, when I mourn that loss, I begin to think about where that knowledge now resides? And surely the answer must be that it resides here. In this Society. In each of us. If we can successfully mourn this loss, and others too, then we can continue to develop the work ourselves and in that way keep what is of value alive, without fear of disapproval, and without the otherwise inhibiting inner comparison of one's own efforts with how the parents' efforts are perceived if they remain idealised and unmourned. Good parents (at least to a sufficient extent) want their children to flourish and be different from themselves, to gain the independence of adult functioning; and to achieve this, as a child, you must have an internal parent with an encouraging voice: a real human being not a God or Goddess. Whereas it might readily be accepted that the failure of an individual to grieve a significant loss is likely to lead to problems in maturation, perhaps the same is true in the collective life and development of a Society such as ours as well, which also has a need to develop adult functioning – to develop relationships and structures which will provide for the future. Perhaps the considerations of organisational development become more important as direct contact with founding parental figures becomes more distant?

Am I alone in thinking that the Society sometimes not only embodies an unresolved grief for its founding figures but perhaps also for the group experience itself. It is not surprising, not a bad thing, that after such a significant professional experience – that working together in a group often is for us – that we should want to continue meeting. But to be productive when we meet, in these our evening meetings for instance, do we give enough thought to what the true intellectual Agenda of our Society should be, assuming that it is functioning with adult self-respect and a belief in the value of its own work (Balint) and our own work (as GPs). Do we not betray our state sometimes by an over-reliance on outside sources? Is this a remnant of our dependent relationship on the leader in the group process?

The group method that the Balints developed – both for training and research – is the main vehicle for our work, and the Society rightly concentrates its efforts on promoting this approach to the study of GP work. The importance of this activity should not obscure other aspects of our Society's work from being developed. Once a GP has been a member of a group – and has become a Balint graduate (!) – how well does our society cater for the professional interests that such an individual might have? Is it our job to think about this?

Whilst considering this problem, an additional thought occurred to me. If we can think of our own Society as a child of our Founding figures, what is the state of our relationships with our siblings, and other relatives? This question becomes more important, if as seems likely to me, we can only pursue the objective of a fuller intellectual life for prospective members by beginning to make improved links with other like-minded societies and similar organisations. There are an increasing number of professionals with interests closely related to ours who know little of the Balints' work. Our siblings must be the members of the Institute of Psychosexual Medicine, and the Association for Psychosexual Nursing. There are also quite a few psychotherapists (and counsellors) in practices who we might find we are related to, distant cousins perhaps. And there are still a handful of psychoanalysts who remain committed and interested in Balint work, and maybe some younger ones whose interest we can hope to encourage.

My colleague Jan Wiener and I have been working together during the last year to establish a Primary Care section of the Association for Psychoanalytic Psychotherapy in the Health Service (APP). This section aims to be a supportive network for all professionals working in Primary Care who have a common intereset in thinking about their work from a psychodynamic point of view.

A robust relationship with siblings would seem to require a **clear and confident internal identity** which can tolerate rivalry, proximity, and difference without being overwhelmed, as well as having parents that want you to be able to share family life together and are not too possessive or divisive in the way they share their children with others.

Before telling you about a simple recent case, I want to quote from Jonathan Sklar's paper again. After stating that 'the Balint Society can retreat to the inner citadel of knowing their methodology is sound – that we can possess an inner freedom of spirit, even while we suffer from merely external tyranny,' he returns to his opening (rather critical) remarks about (our old friend) evidence-based medicine and says something with which I completely agree: 'It is the

entwining of the two that makes for the best of medical practice; science with humanity, practised with freedom. Thus, the wisest course is for the doctor to feel free to practice the medicine that is his to practice.'

A recent case

I want to tell you briefly about a woman who I saw a week or so ago. She came in as an unbooked (extra) appointment. I had never seen her before. She seemed nervous, explained that she didn't normally come. A talkative Irish woman in her sixties, pale, tired, depressive facial features, apologetic, and dressed in black, edged with white. Her problem was a cough, a repeated never-ending cough. Going on for weeks. Was it just that she'd had it a long time that made her want to come? Or was there something else about it? It was an unbooked slot, so, was it in response to a recent anxiety? She'd started coughing in church, in a recent mass, goes often to mass, this was the day before, a funeral mass, she couldn't stop coughing, and she'd begun to feel faint, heart racing, giddy and tried to get out as she became alarmed she was going to collapse. She had what sounded like a panic attack. Her words and coughing spluttered and poured on, and I just let her talk ... Only one phrase, amongst many, really struck me – when she was telling me something to do with her medical history – it was an aside **'my husband was alive then'.** It struck me because it seemed unnecessary. It belonged to a different narrative, but had forced itself on to the scene, **almost** unnoticed. When she eventually paused, now in quite different territory, I asked her to tell me something about him and their life together. He had died about three years before. From lung cancer. She came from (and had given birth to) a large family, she had seven children. She and her husband had run a pub for a living. She was very lonely now.

We talked a bit, I examined her chest, she cried for a while; I wondered about asthma, and then I said 'of course this was a funeral mass when you had your attack, I wonder if there were reminders of your husband's funeral.'

Which of course there were ... 'Yes, doctor, it's funny you say that, because' ... and more tears ... And then after we had more fully made this connection, which she hardly had made herself, and talked of the thoughts that raced through her mind ... I was then able to say: 'and of course you husband had cancer of the lung, and perhaps had suffered a lot himself with coughing ...' More memories, more tears ... She visited the church every day, she told me, to talk to her husband who was buried there. Never missed a day...

After probably no more than ten minutes she left, considerably relieved, and we ended the consultation, both of us, with more energy, not less, than at its beginning.

Why have I chosen this case?

It is a simple piece of GP work. I have no doubt that such cases are the unsung everyday occurrences in surgeries up and down the land. It reminds us of the work that only GPs can do. Our expertise lies in the connecting threads. In the interplay between body and mind; mind and body. And across time. We should never forget the importance of our being the only medical discipline that needs not make any such distinction. It reminds us that only a little can be quite a lot. That although we bring our **problems** to our groups (perhaps overmuch), we should not forget our satisfactions and the value of the work that we can do well. The value of this work to patients (and to ourselves) needs representing clearly. Who else will do it? And that the purpose of our efforts is not only to share the load of the near-unhelpable but to make us more effective doctors and to help our patients in ways in which they **can be** helped. And to feel free to do it **in our own way,** because that is where a large part of the medicine lies! This was my consultation. Not yours. Yours would have been different. And equally valid.

As well as selecting this patient because of her difficulty in facing a bereavement, it is true that this an area of experience to which I have sensitised radar. And this observation would take us back into groups, and research. After all, such a consultation is no more than a starting point. Now we must follow. and how can we ever follow amidst everything else that is going on? Even if we can, as soon as we deliberately follow we alter. Yet we can't easily accept anything less as it falls short of our central interest. GP work. Not just little bits. And we will need to distinguish between the Doctor and the Patient. Was it my choice? Her choice? Mutual selection? What are the effects of these things? How can we study? How can we describe?

'That we can possess an inner freedom of spirit, even while we suffer from merely external tyranny...' I like the word 'merely'! In our own work we can possess an inner freedom, and be confident in the importance of this for other doctors. Our task is to clearly distinguish between inner and outer in this respect; perhaps particularly at a time when it seems that the outer is markedly less free.

Our evidence in the end is that we appeal to something deep in the spirit of our fellow professionals. But we need clarity about tricky things; what we stand for, who we are, what we have to offer, the value of our work and our pursuit of it, not proof, but inner belief in value. And stated in fuller terms than simply stating our belief in the value of Balint groups, per se. A value clear to us from our experience but one that does not immediately have meaning for others.

'Thus the wisest course is to feel free to practice the medicine that is his to practice' This is a deceptively simple phrase but one that is full of meaning. It helps us to remember that despite the current pressure for conformity, we are alone when we consult, just two individuals are present, and that my way of practising medicine is not the same as yours, and that that is unavoidable, and should not be a cause for embarrassment. It is a

truth that needs greater recognition, even though at the present time it is unpopular. Balint work does not seek to train doctors in correct or beneficial therapeutic skills, but to help them possess more fully what is only theirs to practice; and that these two things – therapeutic skills and a doctor practising his own medicine are related but are not the same thing.

Before leaving this question of freedom, I want to add another thought about the organisational position of our own society. An important part of our methodology is the study of what is often called parallel process – most usually this refers to those dynamic processes that seem to reflect and reverberate between the doctor-patient relationship, the dynamics in the group process, and how the leader may (or may not) get caught up in those dynamics during the discussion of case. I would suggest that there is also a connection between the freeing of a doctor's own way to practice through the work in a group; the freedom with which a group and its leader can give itself to that task; and the freedom of the Balint Society itself as a Society with no other axe to grind than the study of these things. Perhaps this is a virtue of particular importance at the present time, even one to be proclaimed. In being outside other structures, either the current interests of PCGs or Trusts, or even the educational structures themselves which seem to be more and more out of sympathy with our approach.

Therapists in Primary Care

During the same length of time that our Society has been in existence, there has been a parallel series of developments in the field of psychotherapists and counsellors coming to work with us in our practices. This move began within five years of the founding of our Society in 1969 and has now been in existence for at least twenty five years. There are currently about 40% of all practices who have counsellors or psychotherapists working with them. There was a slow but steady increase from the 1970s onwards, mainly in practices where psychologically minded doctors (often Balint) took the initiative. It took some motivation, and commitment to funding to get such posts off the ground in the early days, as well as some knowledge and familiarity of the therapeutic world. There was then a great mushrooming in the 1990s to the present figure of 40% of practices or more. This seemed driven to a certain extent by fundholding and the forces of fragmentation, and the interests of Trusts in developing this work, and the large number of counselling trainings available by this time.

The Balints often frowned on this development. Perhaps rightly, to a certain extent but times have changed. Founders are often jealous gods, or at least seen as such. A senior colleague told me quite recently how dreadful he felt when he even mentioned a counsellor in a Balint group once. Although this seems excessive, perhaps there were some good reasons for the Balints' note of caution, or even discouragement, connected to the great difficulty of distinguishing between the work that only doctors can do, and in which we need encouraging, and for which the Balint group is the pre-eminent method both for training and for research – and the work that can be done and might be better done by other more suitably trained professional colleagues. These are difficult distinctions, and we are chronically (near-incurably) deficient in our powers of self-recognition, as far as GP work is concerned. As GPs we spend much of the time in the shadows of other people's lives: as a missing son, a parent, a lover, a friend, but we also spend much of our time not quite seeing the value of our own professional selves in that shadow, and what purpose it is that we're fulfilling for our patients. As has so often been observed, we are often 'doing' much more than we notice, and particularly at moments when we think we are doing least! It is still a painful moment for the leader of a Balint group, and perhaps one that occurs more frequently nowadays, when a presenting doctor after discussing his/her patient with the group and often making it clear how much intricate and often excellent work is proceeding – GP work – says that he/she feels she ought to refer the patient for counselling.

However, if we can learn to understand and respect each other's work more fully, there can be many advantages for patients if psychotherapy is brought closer to patients in primary care teams. I am referring to clinical work mainly, but also to thinking together, exploring thoughts, researching, teaching about these things as well. Without such collaboration, and a framework through which such collaboration can take place at more than just practice level, how can we even begin to study the many questions that arise? How do the two fit together? How can we study the effects of a combined approach? how can psychotherapists, or counsellors be expected to really learn about the characteristics and value of GP-therapy without sustained exposure to cases, either through shared work or case discussion. As GPs we're too often on the back foot, deferring and referring! I have often been at meetings where very experienced and thoughtful GPs will-say they 'know nothing' once a word like counselling or psychotherapy is used.

However, we could not be considering the prospect of more collaboration, if psychotherapists had not undertaken the brave journey out from their citadels into the High Street. The origins of this move takes us back to Balint and is influence on those that worked closely with him. Alexis Brook was the first consultant psychotherapist to advocate psychotherapists moving out to work more closely with GPs. His first reports of this work were published in the 1970s. The atmosphere was GP-respectful, trying to understand and augment the GPs' (or the practice's) work with their patients, respecting boundaries, and being careful not to be undermining. It will be noticed that there is a strong similarity between how this relationship – visiting psychotherapist to

practice – is conceptualised, and how the psychoanalyst group leader approaches his relationship to the work of the GP group members.

What are our current Balint Society attitudes to psychotherapist/counsellor colleagues? Are we still a little allergic? Do we still keep a cautious distance? Can we now be clear enough about the value of our more generalist GP (Balint) identity to work more closely with one another? Do we have sufficiently shared perspectives? How much do rivalry and suspicion and uneveness of power relationships get in the way? I'm not sure that the question of our collective relationship to each other, other than at a local level and in our practices, has arisen much before nor could it have done, since there haven't been organisations for counsellors and psychotherapists working in practices. This is no longer the case. What should our relationship be to such a development? My own feeling is that our GP-input into the formation of such an organisation would be very valuable, both for ourselves and for the psychotherapists. In this way we can form a genuinely multi-disciplinary association to strengthen the otherwise often rather isolated inhabitants of the **middle ground** that I referred to earlier. I refer both to individuals and to organisations such as our Society.

Another case

Whereas my first case involved a single patient and a single doctor, I hope my second case will help us think more about the multi-professional and more confusing world that we often inhabit. I also hope it might help us consider the differences between psychotherapeutic work (whether by doctor or therapist) and Balint work.

A few months ago a rather fat young woman, Sarah, came in, in her twenties, obviously depressed. She was tearful, bad tempered, and irritable ... I know her a bit and know that I've seen her a number of times previously, and in fact her notes record that at the age of 17 she had seen me wanting a termination of pregnancy. I feel she expects something from me when she comes, or expects me to know her better than I feel I do. I feel a bit guilty. I ought to know her better, feel more sympathetic. Her familiy relationships are always muddled in my mind, I can never remember who's who and how people fit together.

She tells me that she is married now. For six months. She mentions Angie, her little two year old who I then remember has had lots of illness, and frequent admissions to hospital. She has been seen by lots of doctors in the practice. Sarah talks to me about how she's feeling, and after a while I arrange to see her again. I see her a couple of times, and on one of these occasions I remember who her mother is. In October ... a woman in her late 40s brought a little ginger-haired freckly boy, her twelve year old son. He needs help, doctor. He was still sleeping in his mother's bed, very jealous of her, not even letting her turn away from him in bed. He pestered her mobile if she went out. She felt imprisoned by him. I saw them twice and then referred them for family therapy at a nearby psychotherapy clinic.

Returning to her daughter. On the next occasion I call her name ... a family walk in ... they apologise for all coming ... questioning whether it's OK ... I welcome them. Angie arrives first carrying a little red children's chair from the waiting room, followed by a pleasant quiet smiling Arab man who turns out be Lebanese. The new husband. He understands English quite well but speaks it hesitantly and is difficult to follow. Angie tries to place the chair on top of her mother as though she wants to sit on her, to possess her. When this proves impossible, she settles on her mother's lap, pushing one hand down her mother's dress to play with her mother's breast, and swings her head to the other side and feeds herself from a bottle of Ribena held in her other hand. Sarah seems aggressive towards her husband, he does this, and doesn't do that ... etc., talking about him as though he wasn't there ... I think why on earth has he married her? He seems marginalised, I feel sorry for him, and endeavour to elicit his feelings about their situation, only partially successfully, as his English is not too good, he seems a bit passive and aquiescent. His wife soon takes over again and seems as keen to dominate my attention as her daughter is to dominate hers.

I go into family discussion mode. We talk about their rows, how they came to get married, how they cope with their accommodation and frequent separation. They are homeless. The husband spends a lot of time with his brother. They don't often spend the night together. Sarah has a continuing row going with her mother and remaining younger sisters about being excluded from their New Year celebration plans. She had felt left out and upset. The consultation felt fairly chaotic, and after about fifteen minutes I want to bring it to an end. I finish by making comments about Sarah's difficulty deciding whether she is still a member of her original family, or is now married and establishing a family of her own. On the next occasion I see them, Angie plays with her step-father peacefully, while Sarah talks to me about her terrible relationship with her mother. The following week she comes on her own, and I hear more of her own history of being abandoned by her father when she was very small; and at age eleven being accelerated into a role of premature-mothering as her own mother then had four subsequent children with her stepfather, the last of which was the ginger-haired boy who had practically been brought up by Sarah whilst her mother (in Sarah's view) went out socialising.

I am trying to focus on Sarah's experience of her own mother as a way of helping her with her relationship with Angie. I am thinking about the cross-generation muddles in this family, the separation anxiety, and also wondering about Angie as the next generation patient. Sarah seems to have selected me as a partner in her troubles, how can I understand something about this and possibly use it to help

both her and her daughter? While I continue to see Sarah for my brand of mother and child work, I discover that the Health Visitor has referred her for parenting advice to a behavioural programme at a local nursery. The health visitor's view is that the marriage between Sarah and her husband has been arranged for immigration purposes. I feel naive for not having thought of this, and irritated that she and I haven't communicated better about this family. And, two weeks later, I see a new patient, a Lebanese woman who has been in the UK for 2 days, brought in by Sarah, her sister-in-law, six months pregnant who says she has been forced to run away from her country after being threated with death because she has married a Hisballah, and is seeking asylum. The ginger-haired twelve year old has come with Sarah this time as well! I feel totally at sea in this case. I need a Balint group!

Discussion

As I have already mentioned this case presents us with complicated trans-generational issues of failed separation. It also brings into focus the difference between a psychotherapeutic view – one which might include an assessment of whether a family therapy interview might be useful, and what sorts of family-based intervention that might involve; it might include a more formal assessment of the mother-daughter relationship, and whether Angie's emotional development is beginning to show signs of significant disturbance or not. And on the other hand, a Balint view which would also speculate about such things, but have at the centre of its focus this family's relationship with me, and mine with them. What do I represent for this young woman? What do I feel about her?

We don't have a Balint group in our practice, but we do have our own fortnightly case discussions. Shall I take it there? Others will be there. We all have similar cases. Very important, the Health Visitor will be there. The practice psychotherapist will be there. In our practice we are experimenting with a family therapist/child psychiatrist coming at the moment. He'll be there. Who can assess how Angie is doing? Maybe she's alright. Maybe not. Isn't this somewhere where our attention should increasingly be lying with the advances in understanding about the transmission of psychological patterns across generations?

Maybe it wouldn't happen with this family, maybe it would, but sometimes I leave these meetings with an extraordinary experience of different thoughts and themes being set off by different members of the practice participating in the discussion, and a much more meaningful understanding of these various patterns emerging as a result.

And might not the tradition and experience built up in the Balint Society have a great deal to contribute to the further study and development, and training for teamwork of this sort?

Institutions and the future

Whilst working for five years as a consultant at the Tavistock, I was conscious of a sharp disparity between how that Institution seemed to be perceived from the outside and how it felt, as a GP, to work there on the inside. Trusts have their own agenda and are under considerable pressure within the Health Service at present. In many ways these pressures have seemed to put the clock back. The present atmosphere does not encourage risk taking. Helping in the gearing of psychotherapeutic services towards general practice, although valuable, is not the same as laying foundations for the proper study of GP work. It is to the latter that I have always felt committed. Our history has always been extra-institutional. The psychoanalytical establishment has often been ambivalent about Balint's ideas, just as our medical colleagues have also been. Our legacy comes from the exceptional individuals, starting with the Balints, who were willing and capable of working across the traditional barriers that exist between Mental health professionals and the medical disciplines of the Body. Our presence remains uncomfortable to both our parental institutions of origin. We must accept that this is so, and not let our anger distract us from pursuing our work, **the work that is only ours to do.**

Institutions are slow to change. We must not look to institutions but create a network of links between interested individuals, at least until our culture evolves in such a way (McWhinney) that we gain institutions that can straddle the body-mind divide.

We are the pebbles and it is our task not to get washed away.

Primary Care Section (APP)

As I mentioned earlier, Jan Wiener and I were invited last year to fom a new Primary care section of the APP. In November we held our first conference which was entitled Therapeutic Practice and Practical Therapy: Different Windows on a Shared World? The section now has a group mainly concerned with the organisation of Conferences and workshops, and also a Committee to consider the Section's further development and policies – this committee consists of GPs, nurses and psychotherapists. It is our hope that this section can become a useful umbrella – a network – that brings people into contact with one another who share a common interest in the psychodynamic aspects of their work, regardless of their discipline, but who all work in primary care.

At that first conference there were psychotherapists who were either interested in, or actively involved in establishing Balint groups who were very keen to hear about the activities of our Society and its Leaders' workshop; there were GPs who recognised that they wanted 'supervision' for their work, but who also knew that this had to be different than taking their cases to a psychotherapist either for group or individual supervision; there were GPs who would bring a great deal to a discussion such that we might hold in one of our evening meetings, but who have never been in a Balint group; and there were

plenty of counsellors and psychotherapists fed up with the typical six-session strait-jacket imposed on them, and looking for a deeper understanding of the nature of the GP seeting for therapeutic work; and these therapists were also very conscious that there is no effective supervision available to them at present (or very little) that can take into account an intimate knowledge of the way in which the GP setting differs so greatly from the more usual setting of psychotherapy practice.

I am not suggesting that we should make membership of our society open to everyone, as I think it is very important that our society concentrates on looking after and furthering the distinctive approach that the Balints originated, but I am saying that if we can find a way of participating in the formation of this more heterogenous grouping – who have come to **the middle ground** by different routes and from different professions, but who have a great deal in common as well – it could be beneficial to the further development of our own Society and we have a great deal to contribute to it.

Finally, I want to go back to Michael Balint as an individual asking awkward questions, in this case of his own Society – the British Psycho-Analytical Society. In 1966 a paper published in the International Journal of Psychoanalysis, entitled Psycho-analysis and Medical Practice, he wrote ... 'Should we analysts accept responsibility for developing psychotherapeutic techniques to be used in medical practice?' Clearly the answer to this question has been 'No'. but I want to turn the question around, and ask our Society whether it wants to take on some responsibility for training psychoanalysts, psychotherapists and counsellors about general practice? And I hope the answer will be 'Yes'.

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Give Sorrow Words: Language and Therapy in a Maximum Security Hospital

by Gwen Adshead, Consultant Psychiatrist, Broadmoor Hospital

In this talk I want to share with you some of my experiences of working as a therapist in a maximum security hospital. Broadmoor is one of three hospitals in England and Wales which are "special", in terms of their security, and the possible risk that their patients pose to the community. But Broadmoor is also special because it is a place of tragedy. If the definition of tragedy includes those situations where a man is caught up in circumstances beyond his control, yet definitely of his own making; where as the situation progresses the man becomes increasingly deceived as to the reality of his situation; those situation in which gradually a man's sense of himself is lost as the tragic events unfold; then Broadmoor truly is a tragic place. Each man and woman there is simultaneously the hero, villain and victim of their own particular tragedy, and one of the main thrusts of therapy is to help each one to tell their own story and in so doing find something of the self that was lost or damaged.

Therefore, it is no surprise that many forensic psychotherapists have considered the use of the arts as having special creative potential; and of those therapists none more than the late and much missed Murray Cox. I remember Murray Cox with a special significance tonight because before he became a psychotherapist at Broadmoor Hospital he worked for many years as a GP, and I know that he "cut his therapeutic teeth" on the encounters that he had in general practice. In addition to being an experienced GP, therapist and author he was also a fellow of the Shakespearean Institute in Birmingham, and advised the RSC on some of their productions. More than anyone else I know, he appreciated how the tragedies of Shakespeare were also the most "forensic" plays which would have particular meaning for Broadmoor patients. Murray made it possible for productions of Hamlet, Lear, Romeo and Juliet and Measure for Measure and Macbeth to happen at Broadmoor. For those who wish to know more about those productions, some of it can be found in Murray's book "Shakespeare Comes to Broadmoor".

Murray belived that listening carefully to the language that patients use, especially their use of metaphor, can reveal an enormous amoung about what a patient is thinking. He also believed that the use of metaphor in the therapist's own responses could help to access levels of meaning that were perhaps less conscious to the patient. One of his favourite quotes was from Gaston Bachelard, who described the value of using images which "touched the depths before they stir the surface:. In this paper I am going to talk about speech and language in people with severe mental disorders, including personality disorder. I am going to talk about how speech can be lost as a result of trauma, and ways that therapists can help patients to regain their voice.

Hypothesis

It has been claimed by language theorists that how we view the world and relationships is determined by the structure of the language we use. Although this view is sometimes disputed, it seems to me that the ways that people use language, if not the language itself, does tell us something about what is going on in people's minds, and how they see themselves in relation to others. Speech and language disorders have been studied extensively in psychiatry, most often in the context of psychotic disorders such as schizophrenia. What I would like to do is to look more closely at the language of people with personality disorder, and especially those who have been violent.

The language of people with mental disorders, especially those who have been violent, is abnormal in terms of semantic simplicity and rigidity. This can be seen in terms of a lack of metaphor, and a lack of self reflective language. The capacity to reflect on the sense of self or others is restricted, and there may be less discussion of relationships generally. One may see degrees of falsehood; especially minimisation, distortion and projection. Overall their language indicates a failure of agency or action.

One of the key features of the language of personality disorder is that it can sometimes exhibit a type of "speechlessness". Sometimes it seems that words fail at a time when they are most necessary to express how a person is feeling or what they want to say. In this context sometimes other people's words can be helpful as a scaffold for an individual's own utterances.

Speechlessness

How is it that people lose the capacity to speak and communicate? It may be readily seen that this is a significant problem for man, the most communicating of animals. "To lose one's voice" is a traumatic block on communication, and often occurs at times when communication is most needed. This audience particularly will remember that Freud's first published work was on aphasia, a disorder of speech and communication. It is perhaps comforting to know that psychodynamic thinking and neurology can march hand in hand still to try and understand the experience of people who have lost their voice.

One of the causes of the loss of a voice psychologically is exposure to traumatic stresses. Exposure to the traumas of the first World War led to many psychosomatic conditions include hysterical mutism, or persistent and disabling stammering, particularly in officers who had to give commands. Some early theorists, such as WH Rivers, argue that there was a link between

this type of mutism, and the literally "unspeakable" experience of war trauma.

One of Freud's other early preoccupations (if that's the right word) is that people who cannot express their feelings directly will express them through the medium of the body. Here we step into the literature on psychosomatic disorders, and I am conscious that in this audience there will be many who will be far more expert than I. I want only at this point to raise the notion of psychosomatic disorders in a forensic context, and how the body may be used to express something that cannot otherwise be expressed to consider how people can use their bodies as weapons against others or themselves; and how the use of the body as a weapon might also be a psychosomatic communication.

Many psychotherapists have drawn attention to the importance of communication in therapy. It is hard to see how any therapy could proceed without verbal communication of some sort, although clearly non verbal communications can sometimes be equally important. I am thinking here of Foulkes's describing "The neurotic symptom that mumbles hoping to be overheard". Foulkes argued that in group therapy it can be possible for people to find a voice and articulate their distress rather than acting it out within the groups space.

However, in forensic settings, I think both the patient and the therapist are brought up against "the unspeakable". Generally speaking, the patient has been in the position where they have used someone else's body (or sometimes their own) to take away all the dreadful feelings of pain and rage. They themselves have not been able to contain their own feelings; they use someone else's body to do that. In this sense, I am using the word "contained" in the way that Bion used it, remembering that the container's function is to introject horrible feelings, and "digest them" in to something that can be thought about. Containment therefore is about the conversion of the unthinkable in to the thought. The speech corollary of this may be the conversion of the unspeakable into the spoken.

Security and Language

So far I have drawn on thinking from Freud, Foulkes and Bion in relation to the use of language and therapy. I want now to turn to the work of John Bowlby, and specifically his theories of important of attachment in human behaviour and thinking. One of the reasons that John Bowlby's appeals most to me, is that he uses words which have a peculiar relevance to forensic work, namely security, and the importance of feeling safe. All these issues of course are immensely signifcant in forensic settings.

Most of our patients in the hospital have rarely experienced security or containment at any time in their early lives. In a recent study of special hospital patients with personality disorder, only 18% could be found who had no experience of childhood adversity or neglect. (Coid 1999). Our forensic patients rarely have had an experience of being cared for or thought about. They have rarely had any experience of having their experiences put in to words, which is one of the most important tasks that a parent can do for a child. Very few of our patients have been able to stay in any sort of education which clearly has an enormous impact on the development of language. Therefore, our patients are severely disabled in terms of managing any sort of disorderd feeling or sense of arousal. When an affect comes, it cannot be contained inside and must go outwards;

"No, not that way ... that way madness lies" (Lear).

In this sense therefore violence of any sort is a defence against the experiences of feeling as if one is going mad. Violence releases tension by the translation of feelings into action. The experience of pain and distress is projected into the other person, who is then obliterated, annihilated or triumphed over.

"I took a life because I needed one" (Cox 1973)

"To be furious is to be frightened out of fear". (Anthony and Cleopatra)

Work with Violent Patients

During psychotherapy sessions with such disturbed people, I find that listening closely to the language, and thinking about the metaphors which arise in association to what the patients are saying, helps to make some of the hidden affects clearer.

Consider Mary who killed another young woman when she was psychotic. She began a session with me: "Back for action!". In my mind I made an association with this phrase "Back for action", and

"Between the acting of a dreadful thing, and the first motion all the interim is like a phantasma or a hideous dream".

I held the thought in my mind and later said to her "you took action?". She then responded by saying "I did ... I did a terrible thing ... a terrible time". I then echoed her phrase "A terrible time", and she said "It was a terrible time for me". She then went on to speak a little more about what she had been feeling at the time of the killing and she said:

"It was done ... It was done ... and I can't bring her back ... I would if I could".

This seemed to me to have strong links with Lear's lament for Cordelia.

"She'll never come again ... never never never never".

Throughout there was a strong sense of this young woman's remorse and sense of guilt.

Another example (same patient)

"I just have to pick up the pieces, and go on" (You were in pieces).

"After K died, I was shattered ... I felt completely shattered".

Different Types of Language

I would like to suggest that there are two different types of language, representational and symbolic

language. In a sense these two different types of language mirror two different types of cognitive processing that take place in the different hemispheres. The left (usually dominant) hemisphere does a lot of the work in the terms of day to day conscious cognitive processing and verbal abilities; the right brain perhaps has more role in the processing of negative affects and in the control of mood and arousal, and the language that goes with those feelings. It seems to me that representational language and symbolic language need to work together. I would like to suggest that in major mental disorders, and especially the patients that I work with the synchrony is disrupted which leads to a type of chaotic communication which is frequently misunderstood.

Communicating with carers

One of the most important language tasks that children learn in early childhood is how to communicate with carers. I would like to suggest to you that most of the patients that I see, and especially patients with personality disorders, have either lost or never acquired the capacity to talk to people who might be able to provide them with help. In this context I think it might be helpful to spend a little time thinking about Alexithymia or specifically the difficulty in describing emotional states. Alexithymia is associated with many different psychosomatic disorders. Arguably Alexithymia represents a failure of the capacity to express distress. I would like to suggest that the incapacity to express distress in an effective way is a function of disturbed attachment in early childhood and leaves the child unable to either manage or express distress so that you can be understood, is a complicated task which requires not only a language with speech ability, but also the capacity to reflect on:

(a) inner states

(b) the capacity to monitor them

(c) the capacity to translate them into words

(d) the capacity to appreciate that someone else can understand.

Very few of the patients that I work with in the hospital have this complex capacity; indeed I think it is arguable, that many people, perhaps especially those people whom we call "personality disordered" do not have this capacity. They therefore experience huge anxiety and frustration when meeting up with professional carers. Of course we the professional carers, also experience intense anxiety and frustration, which we sometimes also experience as anger and then there is the rejection of the patient.

Violence and speechlessness

One of my patients said to me that he thought that he was violent because he didn't have words. Violence takes place when language or communication breaks down; one thinks of the phrases "acting out" or again from Julius Caesar

"Speak hands for me!"

Violence can also be a way of not thinking about what has happened.

"I am afraid to think what I have done" (Macbeth)

Shakespeare shows in Richard III how language breaks down. At the beginning of the play Richard speaks in a flawless verse. He engages our attention; he is witty, amusing even sympathetic.

"Now is the winter of our discontent made glorious summer by this son of York"

At the end of the play Richard speaks in halting shattered verse.

"Richard loves Richard that is I am I is there a murder here? Yes. No. I am then fly! What? From myself?".

The murder of the innocent children shatters Richard's sense of self and certainty. He experiences intrusive nightmares; he is irritable, hyper-aroused, and hyper-vigilant. He perceives threat in every personal encounter, and dies alone, deserted by his men. Shakespeare's Richard III (perhaps as opposed to the real Richard III) does contain within it a perfect description of how the persistent use of violence can lead to a disorganised sense of self and a subsequent failure of language.

Conclusion

I hope to have given you a taste of what it is like to come close to tragedy in a setting which is not at all dramatic, but constantly reflects on scenes of great drama. Just as in the theatre, I use my hours of therapy to create a space where the patients can start to give their sorrow words, and translate the unspeakable into something which can be spoken and thought about. It is an ever widening and deepening task, as I experience it; I find now that rather than becoming blasé about this type of experience, I find each murder more baffling that the last, and each piece of work of violence more and more complex. To work in such a complex field requires help and assistance, and the work of esteemed colleagues both past and present; especially William Shakespeare aids the completion of a difficult task.

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Balint Seminars: A Method for Collaborative Care among Rural Family Physicians and Nurse Practitioners

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Abstract

This is a study of an eighteen-month Balint seminar experience with a group of family practice physicians and graduate nurse practitioners in a rural setting. Qualitative research methods were used to explore the potential benefits and challenges of Balint seminars within a rural multidisciplinary medical clinic. Two basic themes emerged: 1) enhanced collegiality among and between disciplines and 2) decreased isolation. Balint seminars, with special attention to leadership roles, should be considered for use among interdisciplinary teams, particularly within rural areas.

Balint Seminars

Michael and Enid Balint conducted small group sessions composed of British general practitioners that were engaged in active clinical practice while at the Tavistock Clinic in London in the 1950s.[1,2] Introduced into the United States in the 1970s, Balint seminars have remained true to the progenitor's focus on the doctor-patient relationship. However, in practice these seminars have primarily been employed to teach medical students and graduate physicians in residency training, not physicians engaged in independent clinical practice.[3-6] The utility of Balint seminars among U.S. practicing physicians, particularly rural physicians, has been little explored. Even less has been reported about Balint seminars with other health care providers or about combining physicians and nurses into a single Balint seminar.

Recently, the Balint group experience has been associated with the improvement of professional self-sufficiency and with the resolution of stressful situations between clients and community-based primary care nurses.[7] The Balint process also has application for stresses associated with profession identity and specialization changes as well as cultural adaptation.[8]

The primary purpose of this article is to describe the formation and development of a Balint seminar as a sustaining link between a rural area and an academic health center. A second purpose is to consider the benefit of this approach for promoting cross-professional development and collaboration in a group comprised of physicians and nurse practitioners. Key outcomes are measured using a qualitative approach.

Background

In 1991, the W. K. Kellogg Foundation funded a project designed to improve the supply and distribution of health care professionals through community/academic educational partnerships in rural areas. Primary health care sites included rural health clinics around which community members, health professionals, and health science students could develop collaborative working relationships. One of these sites is located in the Southern Appalachian area of northeast Tennessee, about a one-hour drive from the university medical campus. Medical faculties working at this site provide clinical experiences for students by collaborating with primary care agencies, teaching communication skills, health assessment and problem-based clinical reasoning, and precepting longitudinal clinical experiences.

The sustenance and maintenance of professionals who live in the rural sites would have a heavy impact on the success of the Kellogg program. Often somewhat isolated professionally, rural primary care providers are perhaps more vulnerable to the stresses common to medical practice. In addition to the many general changes in the medical care delivery system, these particular providers were experiencing consolidation of a family practice physician group and a nurse practitioner group. Nurse Practitioners are graduate level Registered Nurses (R.Ns.) who have achieved extra certification to function in an advanced practice role. This role includes management, diagnosis, and treatment of medical patients, under the protocol of a practicing physician. Thus, professional role identity and health care systems changes were considered to be additional potential stresses. A Balint seminar was proposed in this setting with this group of providers because its purpose is to promote collaboration among health providers, enhance professionals' self-awareness of their roles and responses to patients, and promote appreciation of the clinician-patient relationship. Clinical approaches that emphasize expansion of a medical-diagnostic focus to include an appreciation of a patient's psychosocial narrative are thought to enhance personal awareness, increase satisfaction with one's work and one's collaborators, and improve clinical care.[9,10] The stated goal of this Balint seminar was to enhance the provider-patient relationships. However, we anticipated that through this process there would also be an increased involvement of the parent institution along with increased development and maintenance of strong, positive interpersonal relationships across health care disciplines and perhaps reduction of caregiver burnout.

Balint seminars focus on the relationship between the care provider and the patient and not upon the practice of medicine per se. This was thought to be useful as it could afford prospective participants a 'common ground' upon which mutual altruistic values might be affirmed and through which group support might facilitate adjustment to the medico-cultural changes this group was undergoing.

Methods

Participants and Procedures

In 1997, the Office of Rural and Community Health provided logistical support for the sixteen Balint seminar sessions that met for one hour once or twice a month over an eighteen-month period. On average, six participants met each session and each of the nine participants attended, on average, ten (10.4) sessions over the life of the Balint group. Two leaders facilitated the sessions – one a licensed psychologist, trained and certified by the American Balint Society, has led Balint groups with family practice residents for over ten years. The other leader was a doctoral-prepared RN with experience leading support groups for nurses recovering from substance abuse and returning to work. Both leaders have worked together from many years in clinical training experiences.

Data Collection and Analysis

Using a qualitative approach, three types of data were gathered throughout this project: 1) two short questions were completed by seminar participants at the end of each session. These questions were aimed toward understanding participant thoughts regarding patient care and the impact of the session on clinical practice. After six months of data collection, these questions were altered to explore ways the seminar might have affected attitudes toward patients and other professionals (Table 1), 2) leaders dictated a summary of the interaction process of the Balint groups and, 3) a focus group activity conducted at the conclusion of the eighteen months which elicited participant reactions to the Balint experience.

All responses were transcribed and entered into the QRS NUD*IST software package for purposes of analysis. Responses were coded independently by four raters: the two Balint group leaders, an anthropologist involved with the project as a research coordinator, and a research assistant. These independent coding decisions were then brought to group consensus as to meaning and categorization. Coded data were grouped into three major categories or index trees: 1) provider-patient relationships, 2) insights and self-learning and, 3) the Balint process. Text was then coded into multiple subcategories or nodes. A representation of the index tree, 'Balint Process,' can be seen in Figure 1.

Results

Two types of data are reported in this section: field notes describing leadership issues, and participant responses directed at rural and interdisciplinary experiences discovered through the responses to the post Balint seminar short questions.

Leadership Issues

Dornfest and Ransom[11] defined two primary roles for group leaders: task roles and maintenance roles. Task roles include setting the time frame and creating a friendly atmosphere that encourages experimentation and playful discovery. Maintenance roles include maintaining punctuality, confidentiality and protecting the presenter and group members' emotional well being. As facilitators, our leadership role was to provide an environment to encourage the exploration of multiple points of view. One leader issue involved the selection of a co-leader. It was thought that a nurse co-leader would provide nursing colleagues with a role model peer leader.

Group leaders encouraged both supportive acceptance and risk taking. Group members were encouraged to experience the tension of an unresolved dilemma or to speculate about the provider-patient interaction. This balance was important initially as group members bonded in the group. A parallel balance issue was that of superficiality in case discussions versus the depth that occurred with risk taking. Occasionally group members expounded on superficial details of a case. As leaders, we worked to help the group transition to a more in-depth analysis of the patient-provider relationship, thus intentionally creating some tension.

Vigilance was required to follow the Balint process and to not become simply a support group for these health care providers.[12] Initially, this necessitated interventions to re-focus the group on to the clinician-patient relationship through gentle reminders to consider how the patient might have felt or thought. Sometimes this required that leaders encourage members to discuss how they might have felt in the circumstances as described by the presenter.

Milberg[13] described a number of 'pitfalls' for leaders to avoid. One of the most common was that of providing a particular point of view. In our groups this meant that leaders needed to avoid giving advice on case management or psychological interventions. Since many of the cases were related to the leaders' areas of interest, substance abuse and chronic pain management, it was important to return questions back to the group rather than becoming engaged in an academic dialogue.

As mutual trust was established, the group often became enthusiastic and began 'problem-solving' a case rather than exploring the clinician-patient relationship. Another related 'pitfall' was a tendency of group members to shift into a teacher role. Occasionally members offered a discussion on how to manage the case or questioned the presenter excessively. This occurred several times between a physician and a nurse practitioner and required a redirection back to the client-provider relationship while keeping the emotional tension light and the group 'buoyant'.[14]

Another situation that necessitated re-direction was the serendipitous recognition that group members shared or had treated the same case being presented. During the focus group, several members commented on the benefits of

knowing the particular patient and being able to compare with and contrast their feelings and perceptions.

Seminar members tended to 'socialize' with non-case related discussions. This appeared related to group attendance. If a member had missed several meetings due to caseload or holiday, the tendency was to socialize more. We considered this, in part, to be related to clinician collegial isolation. Socialization was encouraged following the Balint seminar, after the participants had completed written responses to the research questions.

Participant responses

Analysis of the post seminar questionnaire using QRS NUD*IST revealed the highest proportion of responses was in the area of provider/patient relationships (40%). This was followed by insights/self-learning (35%) and the Balint process (25%). Since the focus of this study is the use of Balint in rural and interdisciplinary groups, data will be drawn from the coded category of the 'Balint Process.' Throughout the coding process, the working definition of this category was responses in which participants specifically referred to outcomes which were linked to the experience of having been part of a Balint group. (See Figure 1).

Content elicited through responses resulted in the four subcategories listed under the Balint process index tree. The first was ***insights gained in respect to other group members***. It was of interest that no negative insights were listed in the coded responses. Responses addressed two specific outcomes: a developing awareness of 'oneness' with other providers (nodes: shared reality, mutual understanding, empathy, personality values) and specific clinical suggestions (practice standards). Participants appreciated knowing that others faced the same challenges stating, 'We are not alone,' 'I feel more hopeful because we seem to have similar attitudes, similar problems,' and 'I am very happy to know that other feel similarly about patients and that they have similar reactions'.

Responses coded in ***peer support*** also reflected the dual outcomes of personal affirmation and vicarious learning that could be applied to clinical situations. Comments included: 'This helped support me and give me ideas for energizing emotionally with patients,' 'It is comforting to know that others share my sense of helplessness and I will remember these comments the next time I deal with this,' and 'I feel that other providers are concerned about similar issues and that they will give me support for doing what I think is right and ethical'.

Responses coded in ***evoke emotions*** were of interest since many comments acknowledged the negative emotions evoked through provider-patient encounters, while simultaneously stating the positive outcomes of the Balint seminar. Examples of these comments include: 'Other health care professionals can't always be cool and objective in all situations – I guess you think that you are the only one who has trouble staying objective,' and 'This helped me look at the failing issues of myself and other professionals helping patients dealing with these problems. I felt empathy toward other health professionals dealing with this problem'.

In the examination of Balint process in ***rural and interdisciplinary*** sites, several patterns emerged. The first was identified as problematic for health care professionals who live in rural areas, and centered on the small town dilemma of having friends as clients. Indeed, some participants acknowledged a reluctance to act as physician rather than as friend because of the fact that one may be 'less likely to tell the friends what he does not want to hear'. Despite this dilemma, practitioners initiated solutions by establishing clear boundaries and separating professional and personal roles.

Discussion

An overall pattern that was revealed in the content analysis was an expression of respect and collegiality among members. As one practitioner aptly stated, 'We are all dealing with the same issues personally and with our patients ... this has increased my ease and sense of collegiality'. While other viewpoints were appreciated, sense of one-ness was evident through statements such as, 'there were fewer differences than I originally thought' and the Balint seminar provided a 'sense of a mass community in terms of feelings/attitudes, where MDs feel/think/act the same way as nurses do'.

Data indicate that participants were concerned about being isolated or alienated, reporting that the Balint process provided a welcomed opportunity to develop closer working relationships, 'to be a team with dignity' and 'take you out of your own limits and remove you from isolating encounters'. These finding support Brock and Stock's (1990) objective of enhancing professional self-worth by increasing the respect and collegiality among members. These participants also reported a desire to include other community health care providers in the Balint process.

Conclusions

Professional role identity and health care system changes are considered to be significant stresses for rural health professionals. Shifting from an emphasis on individual fee-for-service to a community-based managed care environment, the health care delivery system in the United States has undergone major changes over the past decade. Concomitant changes in academic health science systems have motivated formation of community and academic educational partnerships. These ventures have increased the distribution of health care professionals in rural areas. However, they also point to the need for viable links to sustain these providers.[15]

Although many of these systemic developments have enhanced health care within rural areas, they also have altered the roles of clinicians within these systems. Often isolated professionally, rural primary care providers may be more vulnerable to the stresses common to clinical practice. Because of this, rural providers have adapted in less traditional ways than their urban and suburban counterparts. The provision of care in rural settings often has required a sharing or blending of duties, as is the case with nurse practitioners. These changes have radically altered the landscape for both rural nurses and physicians, contributing additional stresses to these groups. Two overall themes emerged from the data elicited from participants in this rural interdisciplinary Balint group. These themes of enhanced collegiality and decreased isolation indicate that such an exercise can have positive outcomes which may lead to increased provider satisfaction and more positive provider relationships.

Based on the data collected through this project, we believe the Balint seminar is a method: 1) to sustain links between rural practices and academic health centers, 2) to promote collaborative, cross professional development, and 3) to enhance provider-patient relationships.

The Balint seminar can be a powerful tool for addressing the particular needs of rural health care providers and often the concomitant issue of interdisciplinary practices. Balint seminars should be revisited as a cost-effective method for professional development with special attention being paid to leadership roles.

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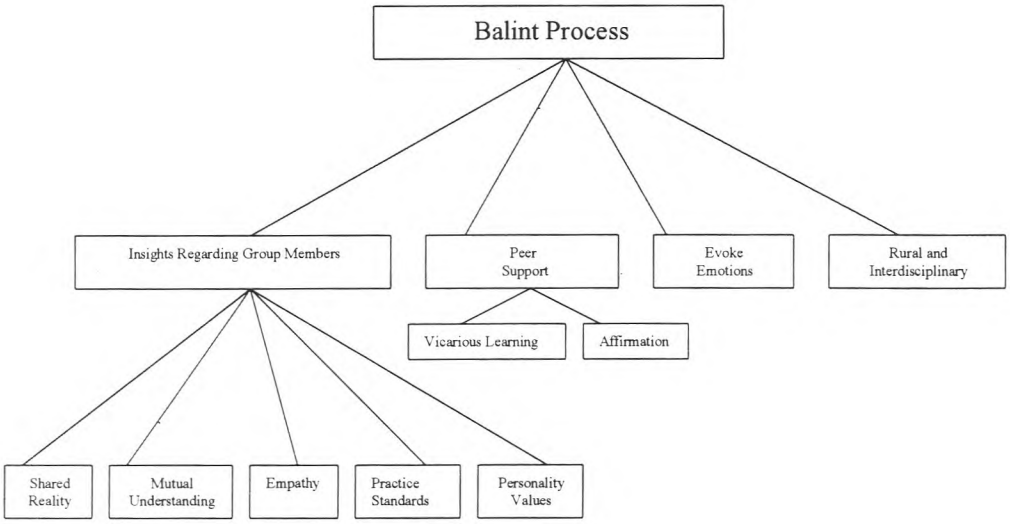
Table I

Post Session Balint Seminar Inquiry

What insights related to patient care did you gather today? (Sessions 1-8)
How will your patient care be affected by what you experienced today? (Sessions 1-8)
How has being in a Balint group affected your attitude toward patients so far? (Sessions 9-16)
How has being in a Balint group affected your attitude toward other professionals so far? (Sessions 9-16)

Figure 1

Results of QRS NUD*IST Analysis



"Six Doctors and a Lunch Party"

by Sue Hopkins MSc.Couns Psych.; Accredited Counsellor, London.

Introduction:

During postgraduate training, I undertook a research project which focused on the doctor's experience of the doctor/counsellor relationship in primary health care, and examined those factors which appeared to me to have a bearing on the quality of the relationship. I had decided to use a grounded-theory approach (Glaser and Strauss, 1967). In-depth individual interviews were arranged with six doctors connected with the Balint network[1], chosen in the hope of their own curiosity about the subject. Comments were also obtained from some non-Balint general practitioners. For the purpose of this investigation, the term 'counsellor' was applied broadly, to any 'psychological professional' working in the doctors' practices to assist with general psychological problems (not to include psychosis).

By the time I had reviewed my tape-recordings, typed the transcripts, and carried out the micro-analysis recommended by Strauss and Corbin (1998), I had become aware of a very rich multi-themed picture of practices (only part of which can be reviewed here), and also of the emergence of certain Balint-style themes, some of with I will describe in this abbreviated report.

It seemed that in general the 'personal style' of the doctor and manner of obtaining the counsellor had a profound effect on the joint relationship and outcome for the service (see also Hopkins and O'Callaghan, 1999). More external factors have also played a part, but less in an objective way than in the way that the doctor has apparently *felt* about these factors.

Some variations were visible from the start, in that although five doctors (XQ, T, U, V and Y) had some kind of counsellor working in their practice, Dr R did not, and never had. This suggested that he might therefore be a 'negative case' in terms of evaluating the findings. In addition, the doctors at the lunch party differed from the doctors mentioned above, in that they were not involved in a network interested in psychological issues. Nor were they expecting to be interviewed. So in some ways, they might offer a slightly different perspective, which might in some respects be a form of triangulation.

All the doctors knew that I was a counsellor, which needed to be taken into account when reviewing the findings. I regarded the way in which they related to me during the interviews as part of the evidence of their feelings about counsellors. This includes my own responses to them, both as an interviewer and a counsellor, putting myself in the picture as a participant. It is important to point out that I was not looking for a 'rounded view' of the relationship with the counsellor (which might involve the feelings of the counsellor and the rest of the practice team), but for a view on the doctor's feelings about the relationship.

The Interviews:

Dr XQ was rather ambivalent about whether it was a 'good thing' to have a counsellor in primary care. Her training had suggested otherwise, but her view of 'reality' was that some delegation was necessary, and indeed congenial. She told an anecdote about how her view of a patient had been changed by what emerged from a counselling referral. She felt this had resulted in a further beneficial change in her own responses to patients: "...a knock-on with other patients...I have looked at them slightly differently as well... perhaps just sitting back in the chair and letting them talk...a magic moment...you may get a magic moment with a patient...that you may not have been receptive to before...so I think it has opened our eyes..."

Dr XQ recognised the importance of boundaries in teamwork, but her comfort in handling collaboration issues varied with her own expertise. This was my first inkling of how the possession of knowledge and information was also an important 'resource' and source of agency, perhaps in a similar way to the role of money. There was some unease about the idea that there might be times when the counsellor might find out something significant that the doctor had 'missed'. There was some mention of boundary problems and 'over-counselling', and the struggle of doctor to retain some feeling of control over this part of the practice organisation.

"...too much involvement with certain patients...wanting to take them elsewhere..."

Dr XQ revealed her lack of knowledge of the actual detail of her counsellor's work, and also, curiously, her personal preference for a psychological model other than the one used by her employed counsellor. As she went on to say more about this, she seemed to become aware of some paradox in this arrangement, and there was laughter. "Perhaps I don't know exactly what I am employing...I actually don't know what goes on downstairs...yes, that puts the cat among the pigeons there..."

This struck me as so odd that I felt I had to 'rescue' her with some information about research done on this subject (Jane Ogden, at Guy's and St. Thomas' Hospitals). She felt cognitive therapy seemed reassuringly practical, and fitted the 'medical model'; "I prefer to understand it; I want to be in control" but was wary of analytical work which she feared might be 'destructive'.

But I still felt there was a paradox. Some time later, at follow-up, I asked her about the apparent contradiction: the counsellor employed was working in a theoretical tradition (family

[1] Members of, or trained by members of the Balint Society.

systems theory) which was not the one the doctor understood, nor would have favoured if she herself had sought help. So why? She answered that the appointment had been made on a whim by C, the previous senior partner, who had been the 'founder' and autocratic matriarch of the practice. The counsellor, H, had been a patient of the practice; C like her and wanted to do her a favour. There was no formal selection procedure, and so it was arranged! Apparently the partners had complied and worked with the arrangement to make it successful.

Dr R had never had a practice counsellor and did not want one. He was courteous, but his positive views about counsellors were qualified. He felt that the hypothetical relationship between the doctor and the counsellor was important, and should be carefully tended. However this relationship was, as far as he was concerned, only hypothetical. In his opinion, a doctor's role was wide-ranging and holistic; any other arrangement would be a 'dilution of responsibility', although if the doctor did not want this role, and a referral seemed 'suitable', then *faute de mieux,* this just *might* be all right. For him, a relationship with a practice counsellor would never be actualised, but he felt quite happy about that, because he was running his practice 'properly', and he felt that many counsellors had insufficient knowledge of psychosomatic medicine or signals of organic disease. "...the ony proper way to be a doctor, a general practitioner, a personal physician, is to be able to assess a patient fully in terms of physical disease, emotional disorder, difficulties the patient may have with his or her relationships...work...anything in their lives which can be upsetting them...causing symptoms...the doctor is in the best position...has an authoritative background..."

He made a strong statement:
"...it isn't what I feel about *counsellors,* it's what I feel about peoples' needs for an overall approach...they don't want counselling, they want medicine."

Dr R was very concerned about "dilution of responsibility" and confidentiality and fragmentation of care. Eventually he came 'straight out' and stated: "...I don't believe a 'team' is the right method of treating people with illness...people find it difficult enough to talk about their feelings to one person, without multiplying it...I think this is one of the tragedies of the Health Service...".

But of course, if Dr R feels that the typpical counsellor is using a different (and less 'right'?) model of patient-care, it would feel difficult for him to engage with that, and work collaboratively. So, logically, he pursues a more independent working method, based on his views about what constitutes good quality care. What was very striking about this interview was its sanguine tone – Dr R felt he was in control of his practice, running it 'properly' in his own way. Control and 'proper' practice seem particularly important for Dr R. In pursuit of these objectives, he may have disregarded the possibility of building collaboration with counsellors.

Dr T spoke very positively about his counsellor (a psychologist). He felt that they got on "very well", and recognised that the quality of this relationship was important. He described her as "very committed...doing her best". He saw the doctor/counsellor relationship as a potential source of interesting discussion about therapeutic issues. He felt it was important to consider referrals carefully and not "dump" patients on her. As he talked, he came up with the idea that he might try to make more time for general and less formal discussion with his counsellor, and felt that would be a good idea, "...thank you for coming along and enabling that thought to surface!".

Dr T also mentioned that he had had a 'friendly' relationship with a psychoanalytic trainee who had had a temporary placement with is practice. He felt that it had been easier to talk to this male doctor trainee than to the psychologist-counsellor. I had the feeling that he was being slightly diffident and 'careful' with her, as he had been with me at the start of the interview, and even in the middle, "...some counsellors are a bit wary of doctors, and some doctors are a bit wary of counsellors..." However, by the end of the interview he seemed less tense, and felt he had enjoyed it and said that "...it gave me access to some thoughts that I otherwise wouldn't have access to..."

He was quick to tell me that his practice does not pay her salary, and that this was a good thing, as they had been saved the trouble of seeking funding, and also the difficulties associated with staff selection. He sounded slightly uncomfortable as he admitted to being glad to avoid these tasks. However, he seemed pleased that there had been some good luck involved.

He had strong views about what constituted a 'good counsellor' with 'good training', which would need to be by a recognised training institute.

He was concerned that badly-trained counsellors might be proliferating. He would prefer someone who shared his own theoretical preferences. As far as he was concerned, "competence" was equivalent to a thorough understanding of psychodynamic work.

Fortunately, the psychologist shared his theoretical model. Of course, in terms of in-house professionals he was constrained by what the NHS Trust was prepared to offer him, and what they were prepared to pay for. This seemed to reduce his feelings of control, and increase his anxiety and tendency to feel that if things were all right it was through 'luck' rather than any other factor.

There were some misgivings, despite his general respect for the psychologist. He felt uneasy about the fate of patients who needed more than brief therapy, and also about the waste involved when patients failed appointments. He would like to see more systematic follow-up, and more interest in the arrangement from the other

partners (which would, of course, need reciprocation from the psychologist, and therefore require more of her time).

Talking to me seemed to stimulate his thoughts about what more he might like from the psychologist, but he pointed out that the time constraints constituted a barrier, since he was only able to have half an hour per month for use on clinical discussions. The time allocated was a spare patient-appointment slot. I wondered how he felt, and what might be the conscious and unconscious effect of being 'slotted-in' like a patient. He said he didn't mind (but with a wry little laugh): "...she's only got so much time...no it doesn't really bother me...it's not something I lie awake worrying about."

This apparent acceptance failed to convince me, it seemed rather compliant for a person of such definite views about 'good therapy services'. I asked myself if he was in denial, and if so, why? When I asked, he quickly admitted that he would really like things to be different, but the funding problem was beyond his control. His voice dropped, perhaps in disappointment. He began to rationalise: "...there's also the fact that I am interested in GP counselling myself...and take on people myself... . So my need for a counsellor is less than it might be...".

Would he be able to ask for more? "...um...er...I can't see why it should be difficult...*and again that makes me think why don't I...*(my italics)...?."

He was puzzled for a moment, but then said he felt he really didn't want to put too much pressure on the arrangement: "...the underlying thing is that we've got to fight to keep the thing going at all...we are lucky to have what we do have...".

But he also speculated as to whether this hesitation might have some deeper roots in his own psyche. He felt that he and the psychologist were broadly in sympathy with one another, but equally, they did not discuss things in depth very much: "...perhaps I treat her with kid gloves a bit...".

"...I am aware that I could be quite prickly with a psychologist who held different views from me...or who was being critical of my attitude...and perhaps I didn't want that to happen with her, so that's maybe one reason why I'm treating her as if the relationship is a bit fragile...".

He had now made the connection himself between the various possible threats to the counselling arrangement and his own rather 'careful' and anxious attitude to the relationship with the counsellor. This new insight seemed to be stimulating; he felt the arrangement should be reviewed.

He recalled that he had not thoroughly discussed with his psychologist how she selected patients for short or long-term work, and was wary of being directive about the subject, despite his own clearly articulated views: "...um...no, I can't see myself doing that, because I'm not her employer or her supervisor...(tense little laugh)...".

In contrast, he told me about the much fuller and freer discussions he had felt able to have with the trainee psychoanalyst "...I must admit that I was quite prickly about him when he first came...didn't know if he would take to us...or to the fact that I was doing some counselling...I could see him taking exception to that and thinking I was meddling in things I didn't understand...and we in fact talked about that, quite a lot... *not in time that anyone was paying for...*(my italics)."

Money and resources seemed to have emerged once more, as a theme connected with Dr T's unease. Shared knowledge as a mutual resource also seemed to be an important factor for him in easing relationships with colleagues. And it seemed as if when he lost control over one of these factors, he felt uneasy, powerless, but also found it hard to locate the problem *accurately.* In his own words, "I can't see why it should be difficult...*and again that makes me think why don't I.?...*(my italics)."

It seemed to me that he not only found it difficult to act, under those circumstances (which might be expected, for practical reasons), but also difficult to *think,* which seemed out of character.

Dr U did not seem very comfortable talking about his 'practice counsellor', who was working there temporarily on an unpaid placement. There was little direct contact with this 'counsellor' (actually a trainee in cognitive behaviour therapy), but Dr U felt that "the staff like him". Dr U also felt that he had a personal preference for counselling services being kept separate from the practice. I noticed that our interview was also 'kept separate' from the practice and conducted at his house (his choice of venue).

Dr U spoke very approvingly of the local hospital psychology service, and also of several local ssemi-voluntary services, where he felt there was "serious therapy". He felt that these services both constituted suitable referral agencies and also felt that centralised services offered certain advantages in terms of choice and supervision.

However, he admitted that he might feel differently if he had more experience of working with a practice counsellor, "...most people do feel very positive about it...and it's wonderful for some patients". I wondered at this point whether this remark was a kind of concession to what he imagined would be my position on this, as a counsellor, because almost immediately he went back to talking about his preference for centralised services.

Dr U felt that "one does get adjusted to a situation where one works". As we continued talking, he seemed to recognise that he was rationalising: "...if you can't offer a service, you work out that the service you can offer is the best way...". Later still, he remarked that the interview was "bringing up things I haven't thought about...makes you wonder...how your col-

leagues actually work, as opposed to what people say they do...". It is possible Dr U had been trying to talk himself into liking a situation in which he had limited choice and control, but other factors involved in "keeping things separate" also emerged.

He revealed the major cause of the unease I had noticed:

"I feel very awkward, because I feel very guilty about having someone who is a volunteer, we can't pay anyone...we can't get any money to pay a counsellor, and the practice doesn't feel that we should pay for a counsellor out of our own pockets..." He seemed particular embarrassed revealing this to me, as a counsellor, "That's not meant for you...", insisting that he felt counselling was worthwhile. There seemed to be little contact between Dr U and the in-house 'counsellor'.

Supervision was paid for, but he was felt to "function very separately" and "he's not a very chatty person either...". However, Dr U went on to admit his own embarrassment with this situation: "I think everybody has this feeling...about being unpaid...(little nervous laugh). And everything has an effect...it makes you feel...um...um...well...that you shouldn't impose...and that makes me feel insecure every time I talk to him..."

Dr U felt that a centralised, specialised service would have enough expertise in assessment to 'match' patients and therapists, and that GPs would not have sufficient knowledge or experience to do this.

Once again, he admitted that he might be rationalising:

"To some extent it's a pragmatic view...I'm not in a position...to offer all that within the practice. And you can often rationalise things like that...". He then began debating with himself about the pros and cons of having a practice counsellor, and raised the questions of easier communication with the counsellor and easier access. But then he said, "you could argue against it" and he did. He also reiterated that patients should perhaps have to make a separate journey to go to counselling or therapy: "certainly serious therapists would say it's unquestionably the way things should be done." "Seriousness" seemed to be a significant theme for Dr U, and I wondered if he was comparing the therapy he had been discussing with some ideal, traditional form.

The CBT trainee in the practice was offering a limited specific intervention for a few patients; I asked if that is what Dr U would choose if he had free choice when hiring a counsellor? This resulted in a frank, but somewhat embarrassed admission: "The idea of hiring a counsellor...really daunts me...not just because of paying...but because of trying to work out who is a good counsellor...or what is the ideal kind of counsellor in general practice really daunts me.... Because I don't have a clue." He went on to admit that it was "hard enough" to choose nurses, even harder to make decisions about less familiar professionals. So what would he do, if he had to? "I don't have the skills, of if we did do it, what we would do, I suppose, would be to second someone from the psychology department to come and do the interview with us..."

Dr U felt that the interview had been quite difficult, because it involved taking a critical perspective. Perhaps he had been anxious that I might dislike his views on practice counsellors. Nevertheless, he had spoken very openly, despite some fears about the 'unstructured' situation.

Money seemed, once again, to provide a focus for discomfort. But it did seem slightly easier for Dr U to admit his unease about the problems of money and resources than to talk about his lack of expertise in choosing a counsellor. Here he did not have 'control through knowledge'.

Dr V made more positive comments about her practice counselling service that any of the other doctors interviewed. I did not intend counting to form a major part of this study, although Glaser and Strauss (1967) note that it can be useful, and may produce counter-intuitive information. Reflecting on the process as well as the content of this interview, I felt that this 'positive flood' might represent not only an account of a positively-perceived relationship, but also some emphasis on communicating this *to me* in a vivid way.

Dr V told me a kind of 'story with a happy ending' about the history of her practice counselling service. This had begun with a fortunate offer of an attached social worker, and this was felt to be a great success: "...she was absolutely fantastic...we couldn't believe our luck." It had been easy to arrange clinical feedback discussions, and the arrangement was felt to be "an amazing learning experience."

Now the practice had two 'counsellors' – one a psychologist. Dr V spoke very warmly of both, and seemed pleased to have a choice. The counsellors came to clinical meetings, "so we are quite spoiled really". She described careful consideration of referrals, "they will think they are going to see somebody good, and they are." Once again, I felt she was talking as if she felt she had received a wonderful treat.

Dr V then went on to describe in detail her referral process, using several anecdotes to illustrate how she tried to match patients to counsellors and 'customise' the referral. I thought a lot about how hard she works to have things the way she wants, using charm as well as effort. I offered her the hypothesis that she was making most use of the service over which she has most control, and she seemed able to validate that. "I think that's the secret of a primary health care team, that everybody must respect, and have confidence in people, and understand their roles." She emphasised this respect by stressing the avoidance of 'dumping': "It's no use just thinking that it's somebody to *deal* with that side of the practice..."

Dr V seemed to understand the impor-

tance of reciprocity, "we try to be accessible...to the counsellor and psychologist...it seems to work." After this, she reflected that "it all sounds so cosy! ...maybe you just got me at a good time, but honestly...".

It was indeed a 'rosy' picture, and I felt a 'rosy' atmosphere during the interview too. However, it seemed probable that the positive, communicative relationship pattern which emerged in the interview exists in Dr V's practice and is facilitating. It is also probable that the 'story with a happy ending' which I heard is also the one which is told within the practice team.

Dr V had little to say about problems with her own practice counselling service. She seemed prepared to engage with any that arose, but downplayed their impact. When the post for the 'externally funded' counsellor had been threatened, the practice fought hard to retain the funding, even engaging in a research project involving a psychiatrist, with that sole object. Dr V rather engagingly admitted to her ulterior motives with regard this research, which in turn set me thinking about the possible gap between what professionals say about research-based practice and what actually happens.

So were they <u>any</u> problems? Well, supply and demand did not always match, but even then, Dr V felt that her "experienced people" managed their waiting list well.

It occurred to me that the positive experience of generosity and good fortune, early in the history of the practice, (a kind of "early good mothering?") might have become bound up with subsequent ideas and constructs about counselling service organisation. Negative comment seemed to take a secondary place.

I enquired whether anything had been forgotten. She commented that "they don't all get better...but maybe it's one of the things I've got sorted out in my head". My own feeling about this was that she was saying that she had separated out the issues about what caused her to feel good and competent, and what might be possible for the patient. Perhaps therefore she felt able to avoid putting pressure either on herself of the patient.

Dr V reflected on her defence mechanisms against feeling overwhelmed: "...the worst time was when we didn't have a counsellor... somehow we just managed...and the other thing is that you don't always take up the clues that you find, do you?...I think I'm quite good at that, ignoring on a hectic day...just not following something up." She also reflected on the obscure factors which might influence referrals "...and the thinking time, which might be in the car, or in the bath...a lot goes on...that one isn't aware of...She quoted an article about the 'mind-space' given to patients (Salinsky, 1996).

She then added: "...part of me thinks that logically, the more pressed I am, the more people I refer... . But I don't think it works like that at all...it's the reverse...*when I'm really pressed, I just don't think psychologically...*(my italics)...I don't take it up...".

So referral criteria might be intuitive *(and idiosyncratic?):* "It's my own evidence...I must say...the very words 'evidence-based medicine' cause a part of me to curl up and die...*(laughs)".*

Interestingly, after the tape was turned off, Dr V made some quite astringent remarks about the "over-selling" of some "quick-fix" solutions in counselling. It is interesting that she did not say those things for the tape. So maybe her negative feelings exist, but are not 'recorded', either literally or metaphorically!

Dr Y, in contrast, had very little to say that was positive about the relationship with his practice counsellor. The counsellor in question was also the practice nurse, who had undergone some further training, and now fulfilled a dual role. He did mention that although there was no real audit of the counselling service, he felt her abilities were limited, although she was "terribly kind". Her work might act as some preliminary assessment for patients who might need further help.

Dr Y had agreed to the interview very promptly, despite rather short notice. This surprised me, but as he talked it began to become apparent that he might have needed a safety-valve!

He said that his practice counsellor, who had a dual role, exercised some of her own initiative with regard to selection of patients for counselling. Despite guidelines having been given to her by the doctors about allocation of time, these had been disregarded; 'favourite' patients were seen for much longer periods, and requests for audit were similarly disregarded until the 'deadlines' were long past. He felt that "a real battle" had developed about the counsellor's working practices.

When asked why he thought he was having these communication problems, Dr Y responded by describing the counsellor: "She's a large lady, and she's an ex-sister from H (large teaching hospital), and she is very *motherly (his emphasis),* and I think she takes people under her wing and she doesn't want to share it...".

Dr Y admitted that there were "management" problems in the practice. I could feel so much suppressed anger in the atmosphere that I queried this, and he laughed. He described exasperating discussions with his practice partner about practice team issues, and unresolved problems. He felt that there was no "rational" reason that the counsellor was retained: He felt that the counsellor denied the importance of audit and administration. Apparently poor time-keeping by the counsellor caused patients in the waiting area to become fractious, and direct their anger towards the reception staff. He said the counsellor did not engage with these problems: "N sails through it all like a five-masted sailing-ship, going on her way."

Dr Y seemed to feel powerless: "...I'm in a very difficult position, because my [practice] partner is exactly the same." He felt that the partner's time-keeping, which was also chaotic, provided a poor rôle-model, and also angered

reception staff. His own exasperation seemed to be fuelled by feelings of dependency: "With the practice bit I have no choice...it was very difficult to find a place in general practice...I feel in a very vulnerable position...". He went on to explain that although he was a partner, there had been considerable legal and financial problems in the implementation of the agreement. He felt that he was trapped in a situation of dependence and resentful compliance.

Given what he had said about his own personality, I wondered how the situation affected him emotionally. He postponed a direct answer, and told me, in great detail, about the problems consequent on the practice premises being too small. Sometimes people had to share rooms, in a kind of 'hot-desking' arrangement: "our working conditions are actually very difficult...the *ratamorphism* of our working area is predominately very, very difficult". He had coined a neologism, which seemed to express the feeling he had of being a laboratory animal confined to a box. He continued to describe the premises in detail, including the dimensions of the rooms. I wondered if his desperation about space represented a metaphor about space for him as a person in the practice.

All this was not without emotional cost, and it was very difficult for him to confront his partner, or any othe members of the team, including the counsellor. Dr Y knew what he wanted for the practice counselling service, but could not find a way to achieve this. He seemed furious and 'paralysed'.

Postscript:

When I encountered the wife of Dr Y at a professional meeting several months later, she told me that the practice counsellor had left, "and they are going to hire a proper one". I wondered how much his exploration of his feelings might have facilitated change, allowing him 'space' to think.

In search of other views, I attended a lunch-time meeting organised by a pharmaceutical company. The doctors I spoke to at the lunch-meeting were very positive about their counsellors, albeit sometimes in a rather unthinking way.

Dr A employed a counsellor/therapist with whom he "got on very well". He did not know anything about this man's qualifications, but he had "got him through a friend of mine". His attitude seemed relaxed and trusting, but uncritical.

Dr B said he was spending large sums of money on counselling services for his practice, and had exceeded the reimbursement allowed by the NHS authorities. He felt he had saved money on the prescription of psychotropic medication, but not as much as had been spent on counselling services. Although I did not know Dr B as a personal acquaintance, I was familiar with his practice area, where there was noticeable social deprivation. Perhaps where there was a high level of psychosocial problems, the doctor would feel more than usually dependent on the relevant services.

Dr E was very keen to talk. "Our counsellor is very helpful...helpful to our patients, easy to get on with...and it helps really in the teamwork aspect of things...that's the main thing to say...". She was so much in sympathy with the counsellor's work that she felt angry with patients who missed counselling appointments. She said that she and her counsellor had rewarding discussions. I felt that the doctor got at least as much (if not more) out of the counsellor's presence as did the patients.

My general impression from this more casual meeting was that the doctors developed positive relationships with their counsellors whenever they were able to feel they had either been relieved of work, or had received interesting input to enrich their work. However, the positive quality of relationship did not seem necessarily related to the doctors' knowledge of detail of the counsellor or counselling process, and this might vary between extremes of ignorance and information.

None of the doctors at the lunch-meeting said anything negative about their counsellors. Their off-the-cuff opinions were all positive, and the tone of these comments was that of a kind of gratitude and relief, as if they really needed team members who would share (or take over?) the responsibilities for emotional problems. The lack of privacy might also have inhibited any adverse comment. In contrast, I felt that the doctors who were interviewed in private were particularly open about both positive and negative factors.

Overall Impressions:

Dr XQ was working hard, with some degree of success, to form a collaboration with a counsellor whose theoretical paradigm was not entirely understood, and who had been hired without her consultation. Her control, and knowledge, in this situation was incomplete, but she coped by a mixture of self-assertion and pragmatic compromise, together with openness to communication and new ideas. But she had not correlated her own ideas about therapy with what 'her' counsellor was providing. Something about the method of choice favoured by the matriarchal late senior partner had gone unquestioned, *even after this partner's death.*

Dr R, by comparison, was making no compromises, and not living with anyone else's decisions. He felt his knowledge of psychological issues was sound, but his relationship with actual counsellors seemed avoidant. The 'counsellor-in-his mind' was a person of limited expertise, who was not seen as offering him anything extra. He valued control very highly, as part of 'proper' holistic practice, and was not interested in trying any other methods. He might be at risk of missing useful and interesting opportunities, but he was happy with his situation. He was also happily avoiding guidelines about the 'practice team'.

Dr T was very interested in, and knowledgeable about, counselling and therapy. He had strong views about what constituted a good service, and

what was unsatisfactory. He was keen to engage in discussions with his counsellor, but felt inhibited in the relationship by anxieties about shared knowledge, also fear of asking too much involvement from a colleague who was funded by an outside authority, and might not be able to stay indefinitely. He talked as if the relationship was fragile, but his anxiety may have prevented him from exploring it more fully, and thereby unduly undermined his efforts.

Dr U was not very interested in the paradigm used by 'his' trainee counsellor. He was embarrassed by the financial arrangements (or lack of them) made by his group practice. This was balanced by his stated belief that 'serious therapy and counselling' worked better if kept separate from the practice and not medicalised. But behind these rationalisations, he also felt that he lacked the knowledge necessary to go about choosing a counsellor and evaluating their work. It was more congenial not to enter this arena of anxiety, and also difficult to talk about it, perhaps more than he had anticipated at the start of the interview.

Dr V was happily and whole-heartedly engaged in collaborative relationships with both a counsellor and psychologist in her practice. She presented as an active decision-maker who focussed on positive experiences, and was friendly and persuasive. The anecdotes she told suggested that she was not only persuasive, but determined and opportunistic. She seemed to feel that she had enough influence and information to know what she wanted and how to get that.

Dr Y, in contrast, was unhappy and angry. He had a good knowledge of psychological issues, but felt completely paralysed by having to work with a counsellor who did not command his respect, in a practice beset with organisational and systemic problems. He felt trapped by financial factors, and felt he had no real control over practice arrangements, including the behaviour of the counsellor. He presented as being even more angry than he realised, and unable to see a way out of his present situation. He was unable to obtain sufficient useful feedback and audit from his counsellor, and he felt hostile towards her.

All the doctors who spoke spontaneously to me at the pharmaceutical meeting were positive about their counsellors. But only one (Dr E) seemed to have developed any depth of knowledge about the counsellor's work. She seemed excited and empowered by this. But Dr A was apparently happy to let someone else choose his counsellor for him, abrogating this responsibility; was this through lack of knowledge? Dr B was spending a great deal of money on counselling services, and seemed to feel rather self-conscious about this. The dynamics of control and dependence can be heightened by the specific nature of the NHS contract, which places a heavy medico-legal responsibility on the doctor as the 'employer', allows open-ended demand from patients, but keeps a tight rein on resources. The doctor is dependent on those to whom he or she delegates, in that any incompetence or lack of co-operation will be accountable upwards. But choice of staff, or other referral services, may be constrained.

It would seem from the above, that money, power, and knowledge, and the *perception* of their availability have a noticeable influence on the doctor/counsellor relationship. Deficits seem to cause not only practical problems, but also distress, and 'blind spots' in the thinking of otherwise reflective people, as if the experience of relative powerlessness was disruptive at some deeper level. This was more likely to become visible as the doctors 'settled in' to the interviews with me. Since I had a 'membership role' in the network to which I and my individual interviewees belonged this may have enhanced their trust, together with the knowledge of shared social meanings. The interviews are not just texts, but represent complex social events, which in some cases triggered off new ideas and plans. (One year later, three of the doctors have changed their counselling arrangements.)

It is not in itself surprising that there should be idiosyncrasies and distortions in the doctor/counsellor relationship, but what *is* noticeable is that these are not only strong but also particularly 'obscured' in areas of powerlessness, and this can be demonstrated in a grounded way. In my view, these findings have particular ecological validity at the present time, when health services are being reorganised. Primary care doctors are ostensibly being offered a larger management role in service provision. Without deeper understanding of the complex interpersonal issues involved, it will be hard to work effectively (*BMA News Review,* 1999). Are the doctors 'informed agents' as they enter this new system? Medical literature addresses them as if they are, operating in a logical, evidence-based manner. This may not be the case. Furthermore, long-standing financial strictures have tended to obscure uncomfortable knowledge gaps. It might be easier to say "The NHS won't give us the money," rather than "We don't know enough about this service to plan and manage it."

Some of the dynamics emerging here are significant in psychodynamic and analytic theory, especially emotions connected with the struggle for control over resources, and the pain of deficit (Winnicott, 1959, on Klein). The maternal archetype, and negative-mother complex seem present as explanatory themes in several of the 'stories' (Jung, 1954). Delegation and dependence can be two sides of the same experience.

It seemed to me that grounded-theory generated from the detailed study of these interviews necessarily included the role played by the counsellor in the doctor's unconscious mind. Strauss and Corbin (1998) recall (p.43) that Hans Selye wrote "...it is not to see something first, but to establish solid connections between the previously known and hitherto unknown that constitutes the essence of specific discovery..."

Response to Feedback

There had been broad agreement from the doctors about my interpretations and conclusions, and they seemed pleased to have the opportunity to comment.

Dr T and Dr V seemed to be surprised at the way they were seen, although aware of some factors that might influence that. Available time also emerged as one of the factors that Dr T would add in to his perceptions of control.

Drs XQ, V and Y have made changes in their practice counselling arrangements since the interviews took place, and considered that increased reflection on this service may have played some part.

Conclusions

Although the primary care *zeitgeist,* as expressed in medical literature, often seems to assume doctors to be in state of 'informed agency', in relation to colleagues from other disciplines, discussion with the doctors in the study suggests that this assumption is unsound, even for Balintians!

The doctors' accounts of their experience suggest that relationships with their counsellors may be strongly influenced by the state of the doctors' own resources, especially in terms of funding and knowledge, and the extent of control over their own practices. If the doctor experiences a deficit in any of these areas, he or she is at risk of falling into a state of 'puzzled powerlessness' in the doctor/counsellor relationship. This quasi-regressed state can give rise not only to practical difficulties, but distressing emotions, and in particular, absence of the awareness necessary for problem-solving.

These phenomena may have implications for other fields in which primary care physicians may be required to manage 'specialists' providing a service.

Conversely, doctors who have resolved the issues of resources and control appear to experience good, reciprocal and interdependent relationships with their counsellors. Understanding by the doctor of the theoretical perspective used by the counsellor was felt to be important, contributing to mutual respect.

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Time and Patients

by Pat Tate

Winner of the 2000 Balint Society Essay Competition

Sometimes an important thing happens suddenly during the consultation - when doctor or patient or, wonderfully, both, have a new insight. It occurs during a mere moment of time, and can be exciting and change-making. The incidence is not high.

More commonly, a change in the doctor/patient relationship comes about through the passage of time: through the prevalence of the relationship. Perhaps this is what Ovid refers to when he says, "The art of medicine is generally a question of time", and why Kenneth Lane described general practice as "the longest art". Significant change of this sort can only come about because of the accumulation of many probably individually unremarkable consultations over a period of months and years, in the course of which patient and physician each formulate an increasingly detailed picture of the other's personality, humour, fears, weaknesses, strengths and prejudices. Consider the young man of 18 who has been a child patient for 10 or 12 years, and who makes his first appointment to see the doctor on his own. "I'm not growing properly" says the good-looking 6-foot-plus youngster. He wants the doctor to inspect his (entirely normal) penis. Where did the courage and trust to initiate that consultation come from, if not from the accumulated time spent in that consulting room with that doctor, dealing with earaches, coughs, sprained ankles and spots?

Similarly, a girl of 15 and her school friend come together for an appointment. She has known the doctor since she was tiny, has been brought in many times with minor illnesses by her mother and latterly, since mother's death, by father. The doctor has spent time in her home, with the young mother dying of cancer. "Doctor, should we have sex with our boyfriends? Does it hurt?" Because of the time shared over the years by girl and doctor, it is possible to ask these excruciating questions with neither giggles nor solemnity.

It is not necessary for the doctor in these cases to have been perfect during all those consultations, all that time elapsed together. Almost certainly, that will not be the case. It is not that the doctor has impressed the patient as uniformingly knowing and wonderful, but that the doctor and the patient have become real people for each other: the drip, drip, drip, of shared time has built up a stalagmite in human form.

Sometimes, people being complicated and unpredictable, the effect of the long-term relationship is to erect a temporary barrier to openness which, once breached, then reveals the strength of the bond built up over time. A middle-aged woman had been taking a non-therapeutic dose of antidepressant for years, and was unaccountably unwilling to dispense with it. When referred to the nurse therapist specializing in coming off substances, the patient revealed her one-year history of bulimia, which the doctor had never suspected. "I couldn't tell the doctor that, because I've known them so long, and what would they think of me?" But she was then able to follow the nurse's advice, tell the doctor, and use the length of the relationship constructively, rather than as an obstacle.

A man in his 30's, lonely and a refugee, developed strange physical symptoms after the death of his only friend. Once physical causes seemed to have been ruled out, he and the doctor agreed to meet for a series of long appointments at the end of surgery, even though the doctor did not find the patient an attractive person in any way. A substantial total of time together accrued, with much in the way of mutual discovery, and the doctor was surprised to discover a genuine liking for the patient. One evening the doctor felt moved to say, "We've talked about so many aspects of your life, but one thing that hasn't been talked about is sexuality." "No, and it isn't going to be", replied the man firmly, and indeed, that remained, strictly speaking, true. But gradually it emerged that, due to intense fear and shyness, he had never had a relationship with anyone - until now. He continued to talk about sexuality, even when, after a visit abroad, he made an appointment to introduce triumphantly his pretty fiancée. The time together had paid its dividend, although he retained his area of privacy.

This issue of time and patients could, in a practical or mechanistic sense, be regarded purely as 'continuity of care', enshrined as a principle of general practice since the establishment of the NHS. But it goes further than that. It is important to remember that every relationship works both ways, and to consider the effect of the patient on the doctor. One obvious effect, noticeable in all the cases mentioned here, is that when a person comes and asks for one's help, it is an enormous compliment and morale-booster. The doctor is grateful to the patient. Aside from those patients we fear or really dislike, the more time spent with a patient, on the whole, the more we like them, and the more grateful we are when they ask our help. They give the doctor a sense of value and of purpose. This can overcome simple uninformed dislike, as in the case described of the young refugee.

When Michael Balint evaluated the results of his initial groups for G.P.'s (Balint et al, 1966) time was one criterion. More than half of the early doctors had dropped out before one year of attendance at a case discussion seminar. There had not been time for the "limited though considerable change of his personality" (Balint, 1957) which was considered the aim of group participation. In fact, it became apparent that successful

'change' took place generally in the third year of group participation. Just as the relationship between patient and doctor benefits from accumulated time together, so does the development of the doctor in a Balint group. "The doctor derives from his work enough "deep" satisfaction to compensate him for the strains caused by the training. In this way he will be able to give up without too much pain some of his accustomed ways of behaving towards his patients" (Balint et al, 1966). But it takes time, patients and patience.

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Ovid. Remedia Amoris.

My experiences as a Balint group leader*

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I felt that it was an important event when, after many years of group work, I first started to lead Balint groups. I was slightly anxious at the beginning. I lived through failures, but then managed to form my own leading from my previous mistakes and avoiding the initial 'acting out'. This learning process will never end. Group leading is a 'dangerous factory' where, besides practice, tact and skill, only good luck can protect one from the impulses waiting to break free within the group.

The relationship between the group leader and the group members is not symmetrical: it can be compared to the doctor-patient, teacher-student or parent-child relationships. Both parties are equivalent in the freedom to express their thoughts, the right to decide and in possessing information. But the leader is responsible above all for the effectiveness of the discussion (which is in fact group therapy) as well for the appropriate boundaries and for protecting everyone from suffering any hurt or psychological damage. For all these things the group members are also responsible, but the level of responsibility of the group leader is much higher.

The group leading style depends on the leader's personality, education, his field of work, and his own state of mind; on the group composition, how familiar the group members are with each other, the circumstances in which the group was formed (whether voluntary or under pressure e.g. as a compulsory element of psychotherapy training) and many others.

I have had the opportunity to become acquainted with the work of many group leaders but none of them were the same. Some are active and dynamic, others are more passive and do not intervene in the group work. There were some who operated with psychodrama elements while others – mainly psychoanalysts – considered free association to be the most important element. There are some who are tolerant, while others give free rein to their dictatorial inclinations. I also met a famous group leader who practically 'gathered' the thoughts, opinions and feelings of the group members and mixed the final discussion out of them, just like a good cook prepares dinner from the ingredients. The result was the work of the group as directed by the group leader; although the group accepted this kind of leading, I still found this very eccentric and a little bit dangerous. The good leader forms his own style on the basis of his self-knowledge, personality and skills – and accommodates himself to the needs and tolerance of the group.

Let us consider a couple of aspects which are good for the group leader to aim for, while recognising that these ideas can not be realised in everyone's case.

One of the most important aspects is the question of activity. In my opinion the best thing is to let the group do its work; imagine, confront different opinions, thoughts, feelings and ideas without the leader interfering. Imagine a bowl, into which everyone puts their own pebbles, eventual pearls, and everyone takes out what they like or need. But no-one, not even the leader, can order any-one to pick this or not to pick that.

If the discussion keeps stalling, the task of the group leader is to try to stimulate the conversation. In this case it is better to encourage the thinking of the participants rather than give one's own opinion: e.g. 'Do you think the patient acted according to his own will or because he was influenced by someone?" In a beginner group or student group where participants have little experience of Balint work or the field of doctor-patient relationships, the group leader must state his own opinion so that the participants can learn. It is helpful if one or two experienced Balint group members or psychotherapists attend such a group and facilitate the discussion. Then the group members can learn the Balint concepts, imagination, patient-approach and the elements of the doctor-patient relationship in such a way that the group leader does not need to intervene.

The generally accepted principle among experienced group members is that the group leader is the first among equals. This aspect is reflected in the title of the book *The doctor, the patient and the group* written by Enid Balint and colleagues and published in 1995. The correct balance between the activity and silence of the leader can improve the work of the group. Conversely, if the balance is wrong, the group dynamic is disturbed.

The group leader should be impartial and enjoy the trust of the group. There are different opinions stated in the group and the members can split into – sometimes very impulsive-debating subgroups. The leader cannot be biased and the members should feel that the leader listens to each opinion with the same interest and gives everyone an opportunity to state his opinion, even if the leader cannot agree with everyone. The group leader is not supposed to favour any group member or to force the acceptance of an opinion or to insist on a particular standpoint. The group leader needs self-control and humility. As far as I am concerned, the greatest difficulty is that the group leader cannot express his own opinion. It is questionable whether he can do so afterwards. One should give an opinion in student groups, or where the group members ask for it, but even then, only a couple of important aspects should be touched on briefly – rather than giving a detailed lecture. In other cases – and I have experienced

* Lecture given to the International Conference of the Romanian Balint Association in Miercurea-Ciuc (Romania) on 17 September 1997.

this – impulses are provoked when new ideas are brought up to which the group cannot react; or the debate goes on with the active participation of the group leader so there is no leader at all – thus breaking the framework of psychotherapy.

According to Michael Balint, the good leader should be a passionate teacher as well. Good team work is a learning process. The leader can work effectively if he has had regular contact with the group for one or two years on a fortnightly or monthly basis, or during weekends with 6-8 meetings each two to three month period.

It is right for the group leader to have a formed opinion about the case: what is the theme (sexuality, addiction, death, suicidal behaviour, anxiety, depression) and what problem-solving options he has in mind. Besides enabling the group members to express their opinions, the group leader should try to steer the discussion in the right direction when it seems to have become diverted and to make the group realise the essential key issue of the case (e.g. guilt, mourning, psychosocial relations of the patient, personality disorder etc). This is important, especially in student groups but can be useful in other groups as well. All cases have their possible-impossible solutions, coping methods, and the task of the leader is to promote the group in exploring these to a great extent in order to find and offer more and better solutions. That is, the group should carry out its challenging work with full potential. However, one can, and sometimes must divert from this intention, and I will return to this below. It must be clear to us that the discussion and the work must be done by the group and if it is not done by them, not even the group leader can force them to do it, or do it instead of them. This thought can protect many leaders from a bad conscience. In the meanwhile, the leader can reduce the tension in the group by emphasising after a seemingly insoluble case, that it is not the helpfulness of the group that failed to lead to a good or acceptable solution, but the extreme difficulty of the case.

In the course of a Balint group discussion, unconscious contents may surface, or hidden feelings, traits, inclinations and acts may be revealed. The group must be very tactful in dealing with these statements. We should avoid forcing anybody to tell us about things which are not willingly told and which the person may later regret having disclosed. It is also unacceptable to use a personal, blaming, hostile or ironic tone. The leader has great responsibility in protecting the members from these kind of attack. The Balint group is Psychotherapy and it is the opposite of its aims and intentions to let participants be hurt or damaged.

It has to be mentioned that Balint groups are attended by a number of members with psychological and personality disorders; there may be people who are on the verge of a crisis (suicide, psychosis) or who cannot face their real problems without the risk of worsening their emotional state. Even in the case of healthier participants it may happen that, during their account, hidden or unconscious experiences surface which are unbearable for them to face. The group, or part of the group, may enter a situation as well in which the tragedy, hopelessness or horror of the presented case exceeds their tolerance. Of course, in these cases the goal is not the deepest revelation as this could drive the participants into crisis, but the avoidance of facing an unbearable situation or experience and to have a discussion which leads to calming, or at least avoids worsening. We should let the emerging defence mechanisms (rejection, resistance, denial etc.) prevail. In such a dramatic group, full of serious risks – a real therapy group – all participants have great responsibility, but the greatest is that of the leader.

All Balint group discussions have a particular rhythm, a certain direction of debate, a characteristic way of stating opinions and counter-opinions and solving the problem. These make up the group dynamics. It is important for the leader to perceive, realistically and sensitively that he is facilitating the development and activity of the group; that he accommodates himself to it, remains in tune with it and avoids disturbing it or stopping it. The analysis of group dynamics is the essential task of leadership training and supervision and it involves a lot of learning.

In order to establish the conditions for group dynamics, for the dynamic itself to be established, to function and be effective, the group discussion should be structured as follows:

1) The case presentation should be brief and uninterrupted, lasting no longer than five or six minutes.
2) The questions that follow should not last more than a couple of minutes. It it takes longer it implies resistance to the discussion. The primary task of the Balint group is not to satisfy the curiosity of the members regarding the case or to hear interesting stories but to help the presenting doctor to move on, as far as the doctor-patient relationship is concerned by confronting different feelings, thoughts and ideas. That is, not to avoid the hard work of discussing the case in depth. This doesn't mean the drama and emotions reflected in the discussion cannot be enjoyable, entertaining and providing good experience at the same time.
3) It is appropriate, and in the West it is an iron rule, that the presenting person withdraws for 15-20 minutes after the questions and doesn't participate in the debate during this time. The presenter should let the group members' imaginations run freely; the group dynamic should not split into conversations between the presenter and other subgroups, discussing aspects that do not relate to each other. The presenter's

defence mechanisms must not inhibit the free communication of the other members' thoughts, feelings, imagination. There are some group leaders, especially psychoanalysts, who after the initial presentation, only allow the presenter to speak again at the end of the discussion. I do not consider this a good practice as the imagination of the group members might become too detached from the particular case, thus providing little help for the presenter. As far as I am concerned, the presenter should be allowed to speak once or twice, to react to the discussion and thus to introduce new aspects to the discussion. The group dynamic is adversely affected and the discussion is delayed if the group diverts from the present case and starts to bring in similar cases, or tries to discuss general issues which arise from the case.

It is appropriate to ask the presenter in an ordinary group (meaning not a leadership training or supervision group) whether it was of some use for him? The advantage of asking is that the group receives feedback on how effective their work has been and the presenter has the opportunity to put into words his thoughts and feelings. The disadvantage is that very often, the presenter's head is full of ideas and thoughts expressed in the course of the discussion which whirl in a chaotic, foggy and unstructured manner, mobilising the unconscious as well; therefore only empty, meaningless, polite words are usually said. I think it is more appropriate to ask the presenter indirectly, suggesting that a statement is optional: e.g. "Do you have anything to add to what we have heard so far?" to which the person either replies properly, or ignores it. If the Balint group is psychotherapy, and it is, we cannot expect the presenter to experience and define all the results by the end of the discussion. In most cases, these are realised only later, and even then it is sometimes realised at an unconscious level and cannot be verbalised.

An essential condition for the effective work of the group is for the group leader to attend leadership training and a supervision group. Without these, leading a group regularly is like rock-climbing without any safety equipment. The best leadership training method I have experienced is when the group and the supervisor gather at weekends for 8-10 times and the supervisor objectively observes the group work. Among participants there is always a different leader, co-leader and presenter. After the one hour Balint group, the supervisor participates in a group discussion for a further half hour, analysing what happened during the case discussion, what was missing from it, what the group dynamic was like, how the the participants integrate themselves in the group and so on. A larger group will divide into two sub-groups, one interior and one exterior, which alternatively discuss the case and then analyse the group work together.

Summarising the above thoughts: The group leader must have professional training which provides him with the skills to deal with the psychotherapy situations emerging in a Balint group. The group leader should carry out his task with great responsibility; to follow the group work attentively with sensitivity and a great sense of realism, and intervene only if the situation requires. When intervening, the group leader must be tactful but determined. Last but not least, the group leader should be modest; he should not force his own ideas on the group but should carefully listen to what is said. He will then find that he will be introduced to a surprising number of new aspects and approaches; he can get to know the personalities of the group members and will enrich his own personality, his knowledge of people and his healing ability. The Balint group is an endless studying opportunity and process as much for the group leader as for the group members.

Book Reviews

Michael Balint: Le renouveau de l'École de Budapest Michelle Moreau Ricaud (2000) paperback pp.300. FF 165 - E 25, 15. ISBN: 2-86586-814-1. Érès. Ramonville St-Agne. (In French)

Michelle Moreau Ricaud is a distinguished French psychoanalyst and Balint group leader. She also brings to this new 'Intellectual biography' of Michael Balint the skill of a historian and the artistry of a writer who can tell a good story. Michelle gives an absorbing account of Balint's life from his birth in Budapest to his death in London. She records his relationships with his three wives and his many friends and colleagues. His contributions to psychoanalytic theory and practice are described and discussed and evaluated. And, of course, she tells us the fascinating story of the birth of the Balint group and the spread of its influence throughout the world.

But what does the title mean? What was the 'School of Budapest'? If you are reminded of Raphael's picture of 'The School of Athens' in the Vatican you will be on the right track. In the 1920s in Budapest, there was a psychoanalytical 'school' of which the presiding philosopher was Sandor Ferenczi, Freud's beloved pupil and disciple. But, Michelle emphasises, Ferenczi was a very different character from Freud; warm hearted, easy going and much more open to ideas different from his own. Under Ferenczi's benign guidance the Budapest school became a place characterised by 'freedom to think, to recognise one's mistakes, to analyse them and to learn from them' (my translation). Michael Balint's psychoanalytic education (including his personal analysis with Ferenczi) took place in this fertile environment which undoubtedly shaped his future intellectual and emotional development.

Michelle then takes us back to 1896 and the birth of our hero. Anyone who knows little of Michael Balint as a person will be delighted by her account of his early years. We discover, that his surname was not actually Balint but Bergsmann and his father was a family doctor living and practising in the Jewish community of Pest. Mihály (as he was then called) had a close and warm relationship with his mother but was rather scared of his strict and authoritarian father. We watch his development as he grows up in Budapest, studies medicine, meets and falls in love with Alice his first wife, fights in the first World War, discovers psychoanalysis, meets a number of other interesting analytic personalities, studies with Ferenczi – and changes his name to Balint.

The Hungarian regime smiled on the psychoanalysts for a brief summer in 1919 and Ferenczi became the world's first professor of psychoanalysis. Then the political climate changed abruptly and the little band of analytic pioneers had to escape to Berlin. They returned to Budapest in 1924 and Balint began a more extensive period of analysis and training with Ferenczi. He and Alice remained in Budapest until 1939. During this time, Michael made a number of important contributions to psychoanalytic theory; and he also began trying to teach psychoanalytical concepts to general practitioners. He started with lectures but soon realised that these were useless and replaced them with seminars in which the doctors talked about their patients. Now that sounds familiar, doesn't it?

In 1939 (Michelle continues) Michael and Alice fled from the impending Nazi invasion of continental Europe and came to Manchester. Why Manchester? Michelle proposes a number of possible reasons which will amuse English readers ('what Manchester thinks today, the whole of England will think tomorrow' he was told by one colleague). In the event it seems that he hated the place which provided 'no atmosphere and no spiritual nourishment'. However, he did manage to take and pass the English exams and qualify to practice as a doctor in England. Then Alice died suddenly of an aortic aneurysm plunging him into grief and even greater loneliness. His second marriage, to Edna Oakeshott ended in divorce after two years. In 1945 he finally moved to London and in 1948 he joined the staff of the Tavistock. The rest of course is history – or at least history with which we are more familiar. But there were many gaps in my knowledge of how Michael met Enid and how the Balint group that we know and love was devised and developed. These gaps are filled admirably by Michelle's book which supplies many interesting details. When the Mother and Father of Balint groups met (significant moment!) Enid was already running seminars for marital case-workers at the Tavistock although she was not yet an analyst herself. Michael's brilliant idea was to dispense with the case notes and to ask the participants to present their cases from memory. Their presentations (and ours) were then like the dreams produced by analytic patients and the discussion was a kind of free association. The method was also very similar to Ferenczi's system of group supervision for trainee analysts: the 'Budapest school' had been reborn.

There is much else in this book to interest and delight the Balint enthusiast. Michelle traces the evolution of the Balint group in England and its rapid spread to other countries. She gives a detailed account of the history of the Société Médicale Balint (SBF) whose activities may be unknown to parochial British readers. There are descriptions of Michael Balint's original psychoanalytical thinking and his books, such as *The Basic Fault* and *Thrills and Regressions.* Michelle also offers us a close up view of Michael Balint's interactions with other famous analysts. During the notorious period of warfare in the London Institute between the supporters of Anna Freud and those of Melanie Klein he

appealed to both sides, in the spirit of the School of Budapest, to stop behaving like oedipal children and to accept each others' differing points of views. His theoretical position was criticised by the eccentric Jacques Lacan in France but Balint refused to be drawn. He wrote Lacan a polite letter offering to send him any English books he may be short of and sending good wishes to Mme Lacan. The book closes with two portraits of Michael Balint by Enid and his son John, interviews with people who knew him well and translations into French of papers by Balint and John Rickman.

I congratulate Michelle Moreau Ricaud on producing this excellent biography. She has a historian's concern for accuracy of detail but she can also bring the personalities of Michael Balint and his contemporaries to life with warmth and humour. I am also rather pleased with myself for having read the book (and I hope understood it) in French. Actually, it was easier than I expected, thanks to my trusty little French-English dictionary and to the directness and clarity of Michelle's literary style. I hope that an English translation will soon be available, but until then, I would recommend any British Balintian who learned a bit if French at school and is capable of ordering a croissant in a Parisian café to have a go at the *version originale*.

John Salinsky

What Are You Feeling Doctor? Identifying and avoiding defensive patterns in the consultation by John Salinsky & Paul Sackin (2000) paperback pp.174. £19.95. ISBN: 1 85775 407 7. Radcliffe Medical Press. Oxford

Michael Balint would be pleased and fascinated by this book. It is the product of the most recent research group working within the Balint tradition – a group which, significantly, takes analysis of the doctor/patient relationship deeper into the personality of the doctor, and crosses the usual boundary between the doctor's personal and professional selves. The cases are beautifully presented, long and detailed. For doctors who have worked in Balint groups there will be a warm sense of familiarity; others will be won over by the attractive simplicity of jargon-free language, clarity of thinking, and honesty. Echoes of the cases recur throughout the book in discussion – a true representation of how patients become in a sense members of a long term Balint group, known to all.

Taking as its starting point the 1978 Balint Memorial Lecture given by Tom Maine, "Some medical defences against involvement with patients," the research group agreed to discuss cases in a very special Balint group – one in which the feelings and defences of the doctors would be explored as part of each case. Traditionally, the doctor's own personality, except in so far as it is part of the relationship with the patient, has been excluded from Balint work. This group, however, has courageously bent that convention, demonstrating that, in the right setting, allowing some focus on the doctor's emotional contribution can illuminate the case.

Balint was determined that his initial groups should not develop into therapy sessions; to this end, he attempted to screen out those doctors who were seeking therapy, and discouraged personal revelations in the group. However, it should be emphazied that the work described in this book does not break with that convention; it is a logical extension of Balint group work as we know it, a development, not a revolution.

Indeed, Balint, in his preliminary BMJ report of 1954, describing the first groups, said:

"The events that are our concern are highly subjective and personal, often hardly conscious or even wholly beyond conscious control ... It may safely be said that these events, happening all the time in everybody's mind, are only partly sensible adaptations to the ever-changing environment; to a large extent they are governed by almost automatic patterns originating mainly in childhood but influenced by emotional experiences in later life. The first task for our scheme was to awaken in the doctors an awareness of these automatic patterns ... Another factor affecting the patient's developing relation to his doctor is the doctor's response, which also is partly governed by automatic patterns. The interplay of these two sets of patterns ... determines to a large extent the efficiency of any treatment ... the doctor ... must become aware of his own automatic patterns and gradually acquire at least a modicum of freedom from them."

I would suggest that Balint's "automatic patterns" mentioned in this passage, are the "defensive patterns in the consultation" of this book's sub-title, and the pivot of the work reported here. This leads me to my only point of disagreement with the book's authors, who state (p.86) that "these defences are not defences in the psychoanalytic sense." I think they are. They represent patterns of avoidance which serve the purpose of minimizing the doctor's anxieties. Some of these have their roots in early childhood as the doctor's anxieties. Some of these have their roots in early childhood as the doctor's personality was formed; others are new or modified forms of defence developed as a result of medical education and practice. All would be comfortably contained within the psychoanalytic concept. They are relatively primitive, unconscious methods used initially by children to deal with threats, anxiety and conflict. When they are used by adults they represent unconscious, often inflexible, methods for dealing with anxiety.

Freud assumed that anxiety occupies a unique position in the workings of the mind, and believed it to be the trigger that initiates defensive functioning. Defence mechanisms defend the self against upsurges of anxiety, but it should be pointed out that they do not defend it very effectively; they have the character of emergency measures, and like all emergency measures, tend

not to serve or function very well. They are of limited adaptive value. They deny, conceal, distort, rationalize or otherwise obscure the truth and inevitably lead to self-deception. They are rigid, inappropriate and stereotyped. They function especially poorly when employed more or less continuously on a lifelong basis. Nevertheless, one could argue that these defence mechanisms are all the self has to defend itself against internal and external threats to its stability, and allow the personality some protection during its development.

In the 1930s, Anna Freud constructed a taxonomy of defences, listing among them denial, repression, reaction formation, projection and intellectualization – all of which are familiar to practising general practioners who examine their own work. It is all-too-well known how emotionally demanding is the work of general practice. Every surgery brings the complex problems of distressed people, along with a demand to solve them. If the doctor engages too fully, he risks becoming overwhelmed and possibly burnt out. If he keeps a safe distance, the doctor is unlikely to be able to help the patient very much, and will feel dissatisfied with the work. Traditionally, the tendency has been for doctors to separate their personal and professional selves by means of defences which protect them from being devastated and disabled by too much exposure to patient distress. The doctor must protect himself in order to survive. But how can the personal and professional shelves be separated, when the latter is merely a specialized part of the personal self?

It is exceedingly difficult in the context of general practice for doctors to adopt a frame of mind which allows them to acknowledge their own vulnerability and neediness when, in terms of their patients, they feel they must appear strong and self-reliant. We learn in Balint work to look more closely at what happens in the consultation, and the research group reporting in this splendid book has taken things further, not requiring the doctor to ponder privately after the group session how his own personality affects the consultation, but allowing him to examine this difficult area within the group, with the support of trusted leaders and colleagues. This may lead to the uncomfortable realization that the defence systems the doctor chooses to adopt in his professional life are similar to those in his personal life. It may prove impossible or undesirable for a doctor to abandon recognized protective defences. But once these enter consciousness, the doctor may be able to use this knowledge and be better prepared in future.

Pat Tate

Caring for sexuality in health and illness, Doreen Clifford, Majorie Rutter, Jane Selby, edited by Diane Wells (2000) pp.326. £17.95. ISBN: 044306443 1. Churchill Livingstone. Edinburgh, London.

This book published in August 2000 is an account of the Balint-based training and therapy developed by the members of the Association for Psychosexual Nursing. One of the authors (Doreen Clifford) gave a talk to the Society last year and the text can be found in this issue of the Journal. We can recommend the book very warmly and Doreen Clifford's paper will give you a taste of it. We hope to review the book fully in our next issue.

John Salinsky

Obituary

Max Clyne, *b* 1910; *d* January 2000; qualified 1936 at Leipzig.

Max had an ambition to be a physiologist before he was forced by Nazi oppression to flee his homeland and settle in Britain. His German degree was not valid for practice in Britain and he had to gain a diploma to achieve registration. He served in the R.A.M.C. in India and attained the rank of Lt. Colonel, which was unusual for a non-regular officer, and seemed to have enjoyed both the work and the ambience. On returning to the U.K. he went into general practice, and remained working in Southall until his retirement. He became a member of that memorable band of pioneers who formed the first group under the leadership of Michael Balint, known in the Balint society as "the old guard", whose work formed the substrate and the inspiration of the seminal book: "The Doctor, his Patient and the Illness." (Sadly, only two of that gallant band are still with us.) After the initial experience in a Balint group, five of the old guard enlisted four new members (including Stephen Pasmore) to study particular aspects of general practice such as: "what sort of patient leaves the doctor's list?"; "patients who ought to have left for very good reasons but had not done so"; and many others. Eventually they decided to concentrate on the topic of night calls. Max eventually agreed to write up the research, and his book "Night Calls" appeared in 1961. After that achievement Max did some research in his own practice on school-refusal, the results of which appeared in his book: "Absent" in 1966. His classical education emerged in the Platonic Greek dedication to Michael Balint: "one of those who carried torches and passed them on to others." I first met Max in the group which produced "Six Minutes for the Patient" and found him rather formidable. Being from the generation born before World War 1, as well as a member of the "old guard", somehow set a distance between us. However, while we were both members of the first Balint Society Council I came to know him much better. It was only his natural reluctance to assume office which prevented him being the second President of the Society. After a few years he seemed to have despaired of the Society's attempts to attract new members in this country and decided to carry the torch back to his native land. He quickly established a network of weekend seminars at approximately six-week intervals in many parts of Germany, which became immensely popular. So successful in fact that there came a time when the Balint seminars established by the psychoanalysts there became rivals, so to speak. However, the Balint movement in Germany appears to have flourished as a consequence of his work. It was sad that illness prevented Max from attending the Congress in Cologne. My fondest memory of Max was at a meeting with the French doctors in Paris, where, because of Armistice Day, the traffic became gridlocked so we had to abandon the taxi taking us to dinner. Eventually, footsore and weary we reached his hotel, where I had to bathe my feet before returning to mine. If there was any distance between us at the beginning of the day it had vanished that evening. His beloved wife predeceased him. He leaves a son.

MICHAEL COURTENAY

Obituary

Robert Gosling, formerly consultant psychotherapist Tavistock Clinic, *b* 1920; *q* Birmingham 1948; MD, FRCPhysch; OBE, *d* 9 February 2000.

'Bob' Gosling was one of the select band of associates of Michael and Enid Balint at the Tavistock who developed the seminars for general practitioners in the 1950s. He had learnt about psychoanalysis from a fellow patient in a tuberculosis sanatorium in New York, where he was on a Rockefeller scholarship at Cornell University for part of his medical education. Subsequently he was unlucky enough to catch polio, and was ill enough to have to spend time in an iron lung. No stranger to suffering, he decided to train as a psychoanalyst and completed his training at the Tavistock Clinic, then still in Beaumont Street.

His British charisma was very different from Michael Balint's Hungarian variety, and from his remarks at Enid's memorial meeting at the Institute of Psychoanalysis he seems to have had a little difficulty with Michael's genius. Nevertheless he was a dedicated co-worker and saw to it that, when he became the first elected head of the Tavistock in 1968, he developed the clinic into a multi-disciplinary organisation ahead of its time.

I first met him in 1960, after being in a group led by Michael and Enid for three years. In that era there was a policy of shuffling group membership after that period of time, but the leader of the group which I joined was on a sabbatical, so Bob stood in for him. After my previous experience with the Balints I found him very austere. My first case presentation in the 'new' group was of the 'pregnant nun' variety, and Bob's response was to ask me why I had chosen the case as he knew something of my track record in the previous group. This shocked me on two counts, firstly, revealing that the leaders discussed their groups in some sort of workshop and secondly, showing that cases were chosen by group members according to an unconscious pattern. While these issues are old hat today, they

were new to me then and I had difficulty handling them. I became very defensive for a time, so defensive indeed that when faced with a 'pregnant nun' case presented by a foreign visitor at an Oxford meeting years afterwards, I was unable to echo Bob's challenge and the group suffered from my incapacity.

Although I met Bob many times, I much regret that I had only been in a group led by him for some three months, as given a little more time to work through my feelings of loss at leaving the Balints, there is no doubt in my mind that my professional development would have been greatly accelerated by his scientific insights and the contact with a man whose cultural interests ranged from Shakespeare to jazz.

MICHAEL COURTENAY

Obituary – Robert Gosling

The psychiatrist and psychoanalyst Dr Robert (Bob) Gosling, who has died aged 79, led the Tavistock Clinic from 1968 to 1979. Already a centre of excellence in the field of psychotherapy, under his guidance it became an international model for such training institutions. Gosling was the first chairman of its professional committee to be elected by his peers, and made significant contributions to group therapy and training.

Born in Birmingham, Gosling became a medical student there and obtained a BSc in physiology. He then gained a Rockefeller scholarship to do his clinical training in the US, at Cornell. However, after six months he developed tuberculosis, from which he suffered for four years.

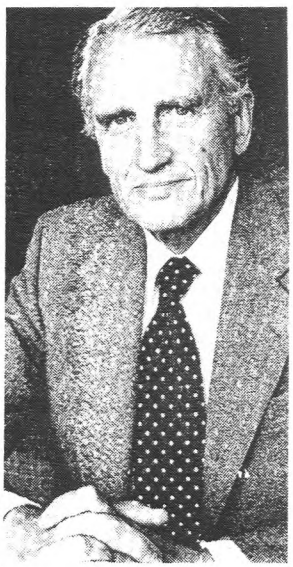
He noted that whether patients got better or worse depended to a significant extent on their emotions. This observation, coupled with meeting a psychoanalyst, led to him settling on psychoanalysis as a career – a perceptive choice, as he was closely in touch with his own deeper feelings.

After obtaining his MD at Cornell, and qualifying on his return to the UK, he worked as a locum GP before starting his psychiatric training at the Maudsley Hospital as registrar to professor Sir Aubrey Lewis. Serious illness struck again: poliomyelitis kept him off work for 18 months, and he had to spend several weeks in an iron lung.

Eventually he completed his psychiatric training at the Maudsley, and became a senior registrar in the adult department of the Tavistock Clinic, acting for several years as assistant to Michael Balint, who was pioneering training for general practitioners. Gosling qualified as a member of the British Psychoanalytic Society in 1958, and became a consultant at the Tavistock Clinic.

Gosling's leadership style at the clinic was primarily that of a facilitator, helping staff of different disciplines to work together, and giving full weight to their shared beliefs in the importance of the insights of psychoanalysis. He enabled them to exercise their particular skills in innovating and developing training programmes. In addition, he encouraged work in schools, residential homes for the mentally sick, and health centres, in order to help staff in their own settings to cope more effectively with the psychological problems they encountered.

A sensitive and insightful clinician, Gosling was often in demand as the "psychiatrist's psychiatrist". The development of the Tavistock tradition of group therapy owned much to him: it aimed at assisting internal changes in individual patients through their involvement with the dynamics of the group.



Bob was strikingly handsome, and had a quiet sense of humour. He was modest, always calm and unflappable, and had a particularly warm way of engaging with people. At the same time he was introspective and, one sensed, deeply vulnerable. He always brought fresh and original thinking to whatever task he was engaged in.

In later middle age, his hearing began to fail and he found it increasingly difficult to continue clinical work, so he took early retirement, and was awarded the OBE.

He and his wife, the novelist Veronica Henriques, bought a Queen Anne house in Gloucestershire, and he combined his hobby, carpentry, with small-time farming. Knowing of this, his friends and colleagues at the Tavistock gave him a goose and a gander. He named them Tavi and Stock – they mated and, to everyone's delight, produced numerous goslings.

In his retirement, Bob became the patron of the Bridge Foundation, a centre for psychotherapy and the arts in Bristol. He was always supportive, playing an active and committed part in its development and success.

He leaves his wife, four sons and a daughter.

Alexis Brook

Robert Gosling, psychiatrist and psychoanalyst, born April 1 1920; died February 9 2000

A shortened version of the Obituary by Alexis Brook, published in *The Guardian* on 15 February 2000 and reprinted with permission.

Obituary – Len Ratoff

Len Ratoff died suddenly on 9th February 2000 aged 71.

He was born in 1929 and qualified in Liverpool in 1954. He served as Captain in the Royal Army Medical Corps in Singapore for three years before settling in General Practice in Toxteth, a very deprived area of Liverpool. He joined the Wednesday afternoon Research group at University College with Michael Balint in 1968, shortly before me, and became a most enthusiastic member. He holds one unbeatable record that he actually flew down from Liverpool on more than one occasion to attend the group under the old Section 63 rules (when this was allowed by his Dean) although he normally came on the train. He contributed several illustrative cases to the 'Unwanted Pregnancy' book by Roger Green and David Tunnadine.[1] He also took part reluctantly in a group research project on terminal care which was chaired by John Hart and was closest to the heart of Michael Balint, although sadly it was never published. He stayed on with Enid's Wednesday group studying random cases for a time, and will perhaps be best remembered as the member of the audience who joined her demonstration group by running onto the stage at the first International Conference at the Royal College of Physicians.[2] He left the UCH Balint group in about 1974. He had a boyish enthusiasm for finding fun in everything he did, which inspired his colleagues and trainees and patients. He was always sparkling with energy for new projects and ideas and will be sorely missed.

He set up multi-disciplinary groups for GPs and social workers in the practice in Liverpool and facilitated Balint work as a lone voice in the North-West Region. He became a trainer and an Examiner for the RCGP and was made FRCGP in 1981. After he retired from General Practice at the age of 60 he began a new career as medical audit facilitator for Liverpool and St. Helens. He was often to be seen buzzing round at College meetings and wrote several books on GP-social worker relationships including 'Social Casework in General Practice' and 'Seebohm and the NHS' and later many articles on education in General Practice. He was awarded the MBE for services to the NHS. He was an enthusiastic traveller, going as far as the Himalayas and became a member of the Royal Photographic Society. He died suddenly in the arms of his wife Pam at 6 a.m. one morning, leaving her and two sons and a daughter shocked and bereft. He had swum 30 lengths regularly till the day he died. Pam, who was a senior social worker, was his greatest supporter throughout their marriage, he would not have achieved half so much without her beside him.

Peter Graham

References:

1. Green, R and Tunnadine D. (1978) *Unwanted Pregnancy – Accident or Illness.* Oxford: OUP.
2. Hopkins, P (ed.) (1972) *Patient-Centred Medicine.* London: Regional Doctor Publications.

Secretary's Report: 1999-2000

The year began with a small Oxford weekend from September 10th to 12th at Exeter College. Thirty delegates attended and had a fulfilling conference. Perhaps the low numbers reflected the large number that attended the International Conference the year before. At the Annual General Meeting on the Sunday lunchtime Dr Heather Suckling was elected President of the Society. In recent years she has been very active in international and national leadership accreditation. I look forward to her three years of office.

The Royal College of General Practitioners lecture series was reasonably, if not heavily, attended throughout the year. As usual we are trying to publish the texts of these meetings in the journal, but we cannot always achieve this. At the first meeting on 26 October 1999 Doreen Clifford told us about the relatively new organisation, the Association for Psychosexual Nursing. A text appears in the journal. Next, on 21 November 1999, Dr Martin Stanton, a psychoanalytic psychotherapist, and Director of the Centre for Psychoanalytic Studies at the University of Kent, gave a historical presentation of the Balint's work, trying to spread the doctrine of psychoanalysis more widely through many kinds of group work. On 22 February 2000 Dr Andrew Elder, previously GP lecturer at the Tavistock Clinic, spoke about the future of Balint work encouragingly, but with the caveat that we can expect little at the moment from the Tavistock. Gabrielle Rifkind, a group analyst, spoke on 14 March with the title "Group Therapy and its Relevance to General Practitioners", a meeting I missed but which the participants enjoyed. The last lecture of the year was on 11 April, given by a wonderful psychotherapist from Broadmoor Hospital, Dr Gwen Adshead, entitled "Give Sorrow Words: language and therapy in a maximum security hospital". Illuminating this strange world of crime and murder, it still had direct relevance to our world of general practice, where other traumas may also take away people's ability to speak and use words. We hope to invite her again in the coming years.

As last year I am sorry to report that, though twice scheduled, the Nurses Study Day did not take place due to lack of interest. The Council thinks that we should put more effort into encouraging practice nurses to come to Oxford, with a reduced price for them.

The work of the Group Leaders Workshop, arranged by Dr Peter Graham, has been very encouraging, with vastly increased attendance and interest. We have recently been meeting in rooms at the Tavistock Clinic which is fairly easy for most people, and have accepted that the strict production of group transcripts may not be an expedient way to present groups as they are so difficult to obtain. Leaders are now at liberty to present process notes of their group for discussion if they wish. Anyone interested in coming to these meetings should send their name to Peter Graham, at Wordsworth Health Centre, 19 Wordsworth Ave., London E12 6SU.

The Annual Dinner at the Royal Society of Medicine was on 29 June and attended by eighteen members. As well as an excellent meal in the gracious Merck, Sharp, Dohme Room we were treated to a stimulating talk from Dr Peter Toon entitled "Balint and the Virtues". He spoke of virtue in medicine in a philosophical sense and how Balint work really may be a way to explore this.

Next on the agenda, on 13 September 2000 is a morning for the Society at Newham General Hospital in London's East End, where we will present Balint Group work to a hospital doctor population at an in-service training morning. Two days later is the Oxford Weekend, from the 15th to 17th of September at Exeter College. It will be the first weekend where we try to incoporate members' short papers in a session on the Saturday afternoon.

DAVID WATT

The International Balint Federation 2000

It is now two years since the 11th International Balint Congress was held in Oxford but the International Federation remains active. We have to plan the next Congress (which I will tell you about shortly) and we have a number of other items on our agenda. The Federation Council meets twice a year, moving from one country to another. In October 1999 we met in Budapest (Hungary) and in March 2000 we were the guests of the German Balint Society who were having a weekend meeting in Aachen which has a magnificent cathedral dating from the reign of Charlemagne.

The council consists of five officers (president, two vice-presidents, secretary and treasurer) and delegates from all the national Balint Societies which make up the Federation. In Budapest, we discussed, among other things, the ways in which new group leaders were being trained and accredited in different countries. Dr Anita Häggmark told us about a new project in Sweden in which leaders are being trained in an ongoing group with both theoretical and practical work. Alan Johnson described the American Balint Society's series of Intensive Workshops for leader training. These are held several times a year in different parts of the country. Aspiring group leaders can attend workshops where they have an opportunity to lead a group under supervision and discuss what happened. Leaders who have acquired sufficient skill and experience can also have their work assessed and if they are thought to have reached the required level, can receive accreditation. Leader training is also going on in France, Germany, Belgium and Romania. There is some concern that this new generation of group leaders may, in some cases have had little or no experience of being ordinary Balint group members. This is especially so in the USA where there are many Family Medicine training programs wanting to start Balint groups from scratch. Nevertheless it is encouraging to hear that there is such a demand for more Balint groups: I can't help feeling that it would be nice if we had such problems to deal with here at home.

At the Aachen meeting (March 2000) these discussions continued. We also heard about some Balint activity in Brazil and about the rebirth of the Danish Balint Society. One of our aims is to encourage any one who is running a Balint group anywhere in the world and to provide support and advice for those wishing to form new Balint Societies. It was also very interesting to learn how many countries are now publishing Balint journals. Our own journal is probably the oldest although it only appears once a year. France, Belgium and Italy have also been publishing journals or bulletins for a number of years. These have recently been joined by the bulletin of the Balint Association of Romania, and, this year, by the German Society's Deutsche Balint-Journal which is to appear four times a year. I just wish I had paid more attention to language lessons at school and perhaps learned German as well as Latin. I do have O level French which means that I can work my way slowly through the French language journals with the help of a dictionary. It is generally well worth the effort.

Finally, the Federation council members are eagerly anticipating the next (12th) International Balint Congress which will be held in Ljubljana, the capital of Slovenia, from 3rd to 7th October 2001. The Congress is being organised by Dr Zlata Kralj who is a family doctor in Ljubljana and has been a Balint enthusiast since she was a student. She and her colleagues are putting together an exciting programme of keynote lectures, demonstrations and small group sessions as well opportunities to see some of Slovenia's tranquil lakes and impressive Alpine mountains. Ljubljana is a friendly, cosmopolitan small city with very attractive buildings and a romantic castle perched on a hill. It has some elegant cafes where you can sip a coffee or something stronger, admire the views, watch the people go by and discuss Balint with your friends. I do hope you will be able to join me there next October.

JOHN SALINSKY
General Secretary
International Balint Federation

29th National Congress of the Société Médicale Balint

A report by David Watt
Secretary of the Balint Society

After several years of being delighted to meet senior members of the French Balint Society at various meetings and again in September 1998 at Oxford, I had decided to attend a Balint meeting in France. I knew there would be two days of group work and lectures, all in French – a test of my language but hopefully a worthwhile weekend for me and for Anglo-French relations.

As well as various other activities the French Society holds one national congress each year with a theme. This year it was "Le Labyrinthe de la Consultation-Sens, Contre-sens et Non-sens dans la relation de soin." The first part of that is obvious, the sub-title a little obscure, even to the French who wondered whether Sens was meant as plural of "way" or singular "sense". It was meant as "Sense, Wrong Sense, and Nonsense in the healing relationship". The venue was a new university building in the city of Pau, which looks out over the Pyrenees, and is the capital of the department of Bearn.

So, on the balmy morn of the 23rd of October I turned up promptly at 8.30 a.m. Not a French thing to do, but we did soon get underway with an introduction given by Marie-Anne Puel, President of the SNB and a general practitioner (médécin generaliste). The weekend was divided into lectures, the general assembly of the SNB and three sessions of small group work. There were 13 groups, each with 11 members, so there were about 140 participants: general practitioners, psychotherapists, psychoanalysts, gynaecologists, at least one rheumatologist and several students and nurses present, partly as helpers for the organisers. The chief mover behind the meeting was Régine Tortes St-Jammes, a local psychoanalyst. Dr Puel dedicated the Congress to the memory of Pierre Bernachon, a very important Balint leader and GP in the early years in France.

The first lecture set the stage for the weekend with a bit of what could be called non-sense but which has much deeper meaning. It was a fascinating analysis of "Alice in Wonderland", a story recounted by Alice to her sister, perhaps in the way of a therapeutic narrative. Other papers gave emphasis to the Labyrinth in trying to use mythological analogies for the consultation à la Freud. The last paper on the Sunday afternoon was entitled "Do you believe that writing is healing?". It was given by a current star of the French Balint world Marc Zaffran. He has written a best selling novel "La Maladie de Sachs" under the pseudonym of Martin Winckler. It has just been released in France as a "major motion picture". He believes that to write, to read, to express ones self is therapeutic, and that it is worth saying so.

The General Assembly on Saturday was interesting for me to compare the work in France with Britain. A fundamental difference is that groups only expect to meet once or usually twice a month, when the meeting will be for two hours and one or two cases will be presented. In France the leader is (almost) always a psychoanalyst and there was discussion about this in the meeting. Another familiar topic to us in England was how one can get the idea of what a Balint doctor can do over to the general public. People asked whether Balint work might help the relationship between French patients and their doctors, which many delegates felt to be very poor. Another very interesting area is that France is just starting to organise a vocational training programme for GPs, which has not existed up until now, and how can the Society try to get Balint work institution-alised into this.

The small group I was in was led by an analyst, Luc Canet and Dr Puel and was very lively. Compared to an English group, there was a great deal of interrupting and also of direct questioning of the presenter, which was allowed by the leaders. The cases were familiar, dealing with difficult patients, difficult parts of the medical system and moral questions. Pre-senters seemed quite unselfconscious and occasionally seemed not to listen well, perhaps because they were constantly questioned by the group. My English contributions were limited and occasionally slightly obtuse when I had felt more of the emotion and less of the exact meaning of the words spoken.

Saturday evening was scheduled for the conference dinner. There was a reception at the Town Hall with a welcome to Pau by the mayor, who was a leading minister in the Mitterand government. He spoke about the debt Pau owed to the English who made it a popular resort in the 19th century and its place as birthplace of Henri IV of France. Dinner followed at the ancient Parliament of Navarre, across a small square from the town's 14th century chateau. Unfortunately we were unable to dance on the beautiful terrace after dinner due to rather heavy rain but it was a wonderful dinner and the quartet played jazz perhaps a bit too well for dancing.

I hope that I was a welcome guest, thank the organisers and the SNB and hope that I will be able to attend next year's meeting in October in Limoges.

The International Balint Conference "Balint groups in different social spheres"

(St Petersburg, Russia – 25-26 May 2000)

The conference was organized by the Russian Balint Society (St Petersburg) and the Department of Medical Psychology of the Medical Academy for postgraduate studies and training. The Academy's authorities gave us their support and welcome during the organizing period.

More than 50 people attended from different regions of Russia (including even Siberia and Kolmykia – near the Caspian sea) and from two foreign countries (Germany and Estonia). They included professionals in many different social spheres – general physicians, psychotherapists, diabetes nurses, teachers and medical psychologists. Some were quite new to Balint work. There was also very specific group of participants (psychologists who work for the police staff and provide their psychological care and support for policemen).

The real problem which challenged us was that the majority of participants had not any previous experience of working in ongoing Balint groups. There were some people who had some experience of stable groups (in our Department) or occasionally visiting Balint groups during postgraduate training courses. The teachers and police psychologists were completely unfamiliar with the ideas and some had never heard of Michael Balint.

The programme included several short speeches (30 minutes):

- Dr Norbert Guenzel (Germany) – "The experience of Balint work in Germany",
- Ilya Pajyltcev – "Balint group and the practice of group analysis",
- Dr Sergey Koulakov – "Balint technology in the supervision of physician and psychologist training",
- Dr Andrey Chechik – "Balint groups as a resource for the multidisciplinary team",
- Dr Friederike Ludwig-Becker (Germany) – "Experience and analyses of multiprofessional Balint groups",
- Dr Vladimir Vinokour – "Balint groups in the overcoming and prevention of professional burnout".

There were also round table discussions and small group sessions. Some groups were multi-professional while the police psychologists were gathered together into one group according to the specific level of their experience in this work.

Establishing the background of the conference, we can say that the introduction of Balint groups into the process of Russian communicative professionals' (physicians, psychologists, lawyers) education and training can positively affect their work, reduce the prevalence of their burnout, and develop their skills of partnership and conducive cooperation. This can possibly help in the promotion of social reforms in Russia; any social progress is possible only through being incorporated into the context of interpersonal affiliation and social support.

Some preliminary findings of the research: "Evaluation of effectiveness of Balint groups in different social spheres" were presented. This study was based on the assessment of seven stable Balint groups by three inventories with statistical analysis. We expect to be able to present this research in a full format soon.

The participants and guests of the Conference were offered an intensive and, maybe, exhausting cultural program (museums, palaces, classic music concerts, excursions around the city etc.), but we hope they were tired *in* St Petersburg, but obviously not *of*.

"It was amazing how you succeeded in the integrating Russia into international Balint thinking and working in it became reality" – Dr Friederike Ludwig-Becker wrote to us afterwards.

We hope more people all over the world will attend our next Conference to enjoy it with us and to make it mutually beneficial.

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The Balint Society Prize Essay, 2001

The Council of the Balint Society will award a prize of £500 for the best essay entitled "Personal Medical Services."

Essays should be based on the writer's personal experience, and should not have been published previously.

Essays should be typed on one side only, with three copies, preferably on A4 size paper, with double spacing, and with margins of at least 25mm.

Length of essay is not critical.

Entry is open to all, except for members of the Balint Society Council.

Where clinical histories are included, the identity of the patients should be suitably concealed.

All references should conform to the usual practice in medical journals.

Essays should be signed with a *nom de plume*, and should be accompanied by a sealed envelope containing the writer's identity.

The judges will consist of the Balint Society Council and their decision is final.

The entries will be considered for publication in the Journal of the Balint Society.

The prizewinner will be announced at the Annual General Meeting.

Entries must be received by **1st May 2001** and sent to: Dr. David Watt,
Tollgate Health Centre,
220 Tollgate Road,
London E6 5JS

International Balint Award 2001 for Medical Students

For more than 30 years general practitioners, clinic doctors, staff members of universities and medical students have met for international seminars at the historical 'Monte Verità' (the mountain of the truth) in Ascona. Owing to their influence on medical training in medical schools these seminars are acknowledged as the "ASCONA MODEL" (WHO), and their main purpose consists in Balint teamwork, examination of the doctor/patient relationship in a group setting.

Medical students are invited to submit a paper based on their personal experience of relationships with patients. An award of **SFR 10'000.** will be made to the author of the best description.

The criteria by which the reports will be judged are as follows:

1. **Exposition:** the presentation of a truly personal experience of a student-patient relationship. (Manuscripts of a former medical thesis or diploma cannot be accepted).
2. **Reflexion:** a description of how a student actually experienced such a relationship, either individually or as part of a medical team. This could reflect multiple relations between students and the staff of various specialities, and working routine within different institutions.
3. **Action:** the student's perception of the demands he (or she) felt exposed to, and an illustration of how he then actually responded.
4. **Progression:** a discussion of possible ways in which future medical training might enhance the state of awareness for individual students, a procedure which tends to be neglected at present.

Six copies of the written submission, each containing the author's name and **full address** should be posted, not later than **31st of March, 2001** to the following representative:
Dir. Dr. med M. Tomamichel, Via Simen 10, 6900 Lugano.

The presentation of prizes will take plce at the Monte Verità Centre, in Ascona, Switzerland on the 16th of June 2001.

Information can be obtained from: Prof. Dr. med. Dr. h.c. B. Luban-Plozza,
Foundation of Psychosomatic and Social Medicine,
Via Monescia 2,
6612 Ascona.

The Society for Psychosomatic Ophthalmology and the British Psycho-Analytical Society

present

The Mind's Eye 2

PSYCHE AND SIGHT LOSS

A one day symposium on Saturday 4th November 9 a.m. to 5.30 p.m.
at The Insitute of Psycho-analysis, 112a Shirland Road, London W9

Course fee £35

For a programme and application form contact:
Mandy O'Keeffe at 67 Avenell Road, London N5 1BT
Tel: 0207 288 2359 e-mail: O'Keeffe@ukgateway.net

Invitation to the 12th International Balint Congress "Balint after Balint"

The 12th International Balint Congress will be held in LJUBLJANA the capital city of SLOVENIA from Wednesday 3rd to Sunday 7th October 2001.

The **programme** will consist of:

- Plenary presentations on the central themes of the Congress by distinguished invited speakers.
- Short papers and poster presentations.
- Demonstration groups.
- Balint groups in different languages.

The **main themes** of the Congress will be:

- The history of the Balint movement.
- The present situation in different cultures and in different professions.
- Balint research.

Papers
Participants are invited to submit abstracts presenting the latest developments and advances in all aspects of Balint work.
Contributions on the main themes of the Congress are particularly welcome.

Congress languages
The official languages of the Congress will be English and Slovenian.

The first announcement will be issued in **September 2000,** the second (final) announcement including the provisional programme, call for papers, abstract instructions and registration form, with accommodation details will be issued in **January 2001.**

Social programme
The social programme for participants and accompanying persons will be organised with excursions to places of general and cultural interest including Lake Bled, the Julian Alps, the Slovenian coast (with Venetian style architecture) and the spectacular Postojna caves.

The host country: Slovenia
The republic of Slovenia is situated in Central Europe and has a number of different regions and climates: Alps, the Mediterranean, the Carst and Panonian plain. With two million inhabitants, it has only one third of the population of Denmark and is half the size of Switzerland, but its unique geographic position and easy accessibility make it a natural gateway between the rest of Europe, the Adriatic and the Balkan peninsula.

The host city: Ljubljana
The cultural tradition of modern Ljubljana, the political, economic, administrative and cultural capital of the republic of Slovenian, goes back for more than 850 years. Its significant role is illustrated by the existence of the university, art academies, libraries, museums, galleries, theatres and, of course, the Cultural and Congress Centre, Cankarjev Dom.

The Congress Venue: Cankarjev Dom
Cankarjev Dom, a multi-purpose Congress and Cultural centre, is located in the heart of the city within walking distance of all the major hotels, shops, restaurants and main sights of Ljubljana.

Easy Access
Slovenia lies at the heart of Europe and is easily accessible from any part of the continent by all means of transportation:

- by plane to Ljubljana International Airport Brnik, situated 20 km North-West of the city.
- by road (highway) from Italy (Trieste 104 km, Venice 270 km).
- by direct trains from all major European cities.

Congress fee: E400 (Euros). Delegates are asked to make their own choice of accommodation from a selection of hotels with a wide price range which will be listed in the 2nd announcement.

Questions about the scientific programme should be addressed to

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S SLOVENIA
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Programme of Meetings of the Balint Society for the Thirty-first Session, 2000-2001

Annual Dinner of the Balint Society **25 June 2001**
Royal Society of Medicine.
1 Wimpole Street, London, W1

Lecture series 2000-2001
Lectures are held at the Royal College of General Practitioners,
14 Princes Gate, London, SW1 1PU.
Time: **8.30 p.m.** (with coffee from 8.00 p.m. except on 3 April 2001 when there will be a reception).

Jeff Roberts, group analyst **24 October 2000**
"Snakes and ladders: some experiences of the psychosomatic interface"

Cecil Helman, Senior lecturer, department of Primary Care and Population Sciences, Royal Free and University College School of Medicine. **28 November 2000**
"Body and self: are they the same thing?"

Chris Donovan, retired general practitioner and honorary physician to the Coram Foundation and Heather Suckling, (general practitioner and president of The Balint Society) **February or March 2000**
"Adolescent Consultations"

The 13th Michael Balint Memorial Lecture: "Psychoanalysis and general practice: What have the Romans ever done for us?" **3 April 2001**
John Salinsky, general practitioner, general secretary of the International Balint Federation.

All meetings are PGEA approved.
Further information available from the Hon. Sec. Dr. David Watt.

Guidance for Contributors

All manuscripts for publication in the Journal should be forwarded to the Assistant Editor, Dr John Salinsky, 32 Wentworth Hill, Wembley, Middlesex, HA9 9SG, UK. Email: JVSalinsky@cs.com

Style

Articles should be typed on one side of paper only and double-spaced. Abbreviations must be explained. Research papers will be peer reviewed to assess their suitability for publication.

References

References should be numbered in the order in which they appear in the text, and appear in numerical order at the end of the article. All references should give the names and initials of all authors, the title of the article, the title of the journal abbreviated according to the style of Index Medicus, year of publication, volume number, and the first and last page numbers.

We welcome the submission of articles on 3.5 inch computer disk. Authors should supply the name of the file on each disk and send a hard copy in addition. Better still, you could send them by email to **JVSalinsky@cs.com**

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